

COUNTWAY LIBRARY



HC 3IBC U

BOSTON
MEDICAL LIBRARY
8 THE FENWAY

M. T.

BOSTON MEDICAL
JAN 27 1913

THE JOURNAL

OF THE
Kansas Medical Society.

VOL. XIII.

KANSAS CITY, KANSAS, JAN. 1913.

NO. 1.

Published Monthly Under Direction of the Council.
Annual Subscription, \$2.00. Single Copy, 20 cents.
501-2 Husted Bldg., Kansas City, Kansas. ❖ ❖ ❖ ❖



Entered as second-class matter April 22, 1908, at the Postoffice, Kansas City, Kansas, under the Act of March 3, 1879.

Grand View Sanitarium —FOR— Mental and Nervous Diseases



THE DRUG HABIT
AND INEBRIETY



Located on Grand View Car Line, Kansas City, Kansas.

Office, Rooms 521-522 Portsmouth Bldg., 6th and Minnesota,
Kansas City, Kansas.

TELEPHONE 19 WEST.

S. S. GLASSCOCK, M. D., Superintendent.

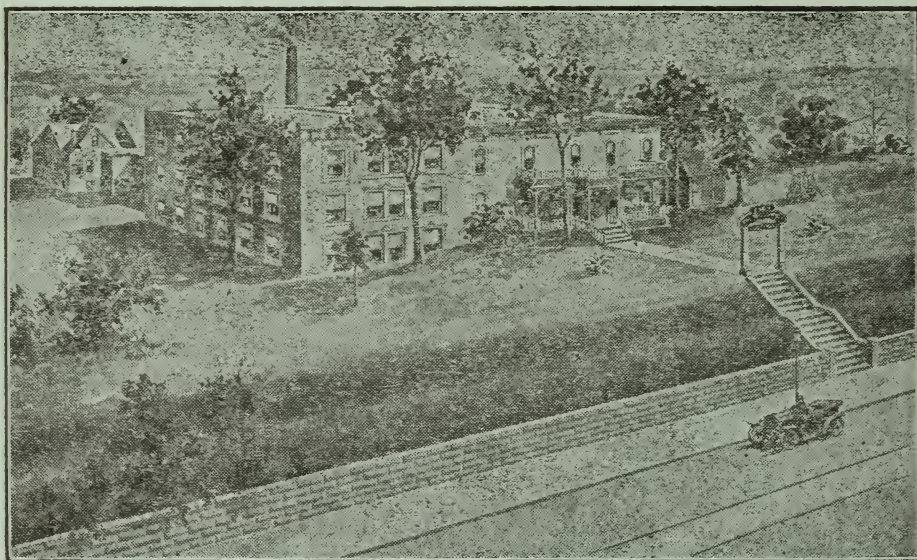
E. P. HAWORTH, Supt.

JNO. W. KEPNER, M. D.
House Physician.

STRICTLY ETHICAL.

The Willows Maternity Sanitarium

SERVING SECLUSION MATERNITY PATIENTS



A Homelike Sanitarium, providing home comforts, home pleasures and home life and aiding high grade unfortunate girls and women protecting their reputations and social standing; rooms meeting the expectations of the most fastidious as well as others to accommodate patients limited in means; room furnishings in the new building elegant and sanitary, and harmonious with the work handled. The location is centrally situated and yet delightful and commanding privacy.

Modern Scientific Equipment, and Methods are employed in the care of both patient and baby. Some of the hospital equipment is: Two confinement chambers, two sterilizing rooms, three drug rooms, massage room, seven bath rooms, silent electric nurse-signal system, intercommunicating telephone system, steam heating and hot water storage system, dumb waiter, dining room for sixty guests, modern equipped kitchen and diet department, two large parlor-lobbies furnished with handsome leather up-holstered davenports, rockers and chairs, library tables, pianos, etc.

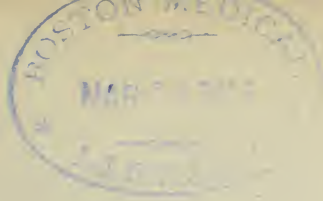
Entering early is important for preparing the patient for accouchement through systematic hygienic methods and massage. Special massage for preventing striae gravidarum, and as aid to labor, can be arranged for. Capable, specially trained nurses care for both mother and child.

Adoption of babies when arranged for. [Only] High Grade patients acceptable. Open to the practice of the Regular Physician.

The Willows

2929 Main St., Kansas City
MISSOURI

Send for New 80 Page Illustrated Booklet.



THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, JAN. 1913.

No. 1

FLAT FOOT AND MANNER OF CORRECTION.

SETH A. HAMMEL, First Lieutenant, Medical Corps, Kansas National Guard.

Read before the Northeast Kansas Medical Society, October 24, 1912.

The importance of the military aspect of this condition was impressed upon my mind and my interest in it aroused by my experiences while detailed with one of the infantry regiments of the regular army comprising the Maneuver Division at Fort Sam Houston, San Antonio, Texas; in May, 1911. In this regiment there were from ten to twenty men who from this cause alone were unable to perform their regular duties or to take part in the long marches that comprised part of the work of this Division and these men would have to be classed as non-effectives in the event of a hard campaign and if taken along would be an almost useless burden. There seemed to be no idea as to what should be done with these men except to discharge them and as most of the cases occurred in men who had just recently joined the regiment with practically a full enlistment period ahead of them it seemed to me that if they were examined and treated skillfully, almost all of them could be cured or at least so much improved that they could complete their enlistment period and render value received for their pay and keep. Figures from the Surgeon General's office show that 40.37 per thousand of the physical causes of rejection of recruits are for flat feet.

A review of the causes of discharge for disability from the United States Navy and Marine Corps during 1910, shows that flat foot is second in number, that the only disease which caused a greater number invalidings from the service was tuberculosis. There is a marked increase in the past few years.

The first step in the prevention of such a condition is to make such a thorough examination of recruits that all exhibiting patho-

logical degrees of this condition be not admitted into the service, this of course is the duty of the medical examiner of recruits. Thorough inspection and palpation of the foot is essential to the recognition of the condition. This can be supplemented by additional procedures such as the time honored method of taking an impression of the sole of the foot. This has been the standard method for years and it cannot be denied that it is in most cases a reliable index to the condition of the arch. Of late, other methods have been suggested, one of which is that suggested by Passed Assistant Surgeon R. G. Heiner, United States Navy. His idea is that on examination of the foot the three following bony landmarks are prominent and easily defined: (a) the lower tubercle of the first metatarsal, (b) the tubercle of the scaphoid, (c) the posterior inferior corner of the internal malleolus. These points are marked with a blue pencil, the patient stands with one foot on the floor and the foot to be examined is placed on the seat of an ordinary chair so as to have the leg vertical and the knee and hip flexed at right angles. A thin transparent celluloid rule with a scale is applied so that its upper edge coincides with these marks on the head of the first metatarsal and the lower edge of the internal malleolus. The distance of the marked tubercle of the scaphoid below this edge is read through the transparent rule by means of the scale. A large number of observations have led him to suggest that an arbitrary limit of depression of the tubercle of the scaphoid of one-half inch be adopted and all showing a greater depression be rejected.

Captain F. W. Wood, United States Army, proposes the standard of function based upon the ratio of the potentiality of the adductor and abductor groups of muscles as compared with the ratio of normal groups. He measures this by means of a spring balance, which is attached to a catch hook on the end of a strap that is secured tightly about the foot at the joint of the great toe. The thigh is fixed to prevent its rotation and lateral motion. He found that the ratio of the average pull of the adductors to that of the abductors to be as 10 is to 8.2 in the examination of twenty-two normal individuals, in simple foot strain where the feet were flexible but markedly pronated and gave rise to definite symptoms of toe and foot discomfort the ratio was as 10 is to 10.8. In rigid flat feet it was as 10 is to 12.2. These results demonstrated that the adductor group normally has a stronger combined pull than the abductor group, but that the latter being favored in weight-bearing by the planes of the joint surfaces, may become the comparatively stronger, over-balancing the adductors and thus favor foot strain.

The admission of recruits with weak feet having been guarded against in so far as is possible the next problem that confronts us is the prevention of this condition occurring among those already in the service and the treatment of the condition itself when it does occur. To do this we should briefly review the etiology of the condition. The essential cause is a disproportion between the burden or strain continuously or suddenly placed upon the foot and the ability of the intrinsic and extrinsic muscles and ligaments to withstand it. It may be congenital, those who are on their feet for long periods of time especially when they do not change position very often, following debilitating illnesses such as typhoid fever, etc. Those who are accustomed to carry great weights, sudden trauma, any continued unusual strain such as the recruit who has not had much active exercise before enlistment would be liable to have to undergo at the training station, ill-fitting and ill-shaped shoes is probably the greatest single factor in the etiology of flat foot.

Anatomy.—The functions of the foot are: to afford a basis of support to the erect body, to act as a lever of the complicated order in walking, to do both in such a manner as to act at the same time as a shock-absorber. Generally two arches are described, (1) an anteroposterior; composed of the os calcis, head of the astragalus, scaphoid, and the three cuneiforms and the three inner metatarsals. The key-stone of this arch is the head of the astragalus and the bearing points are the os calcis and the heads of the metatarsals; (2) a transverse arch which is incomplete taking its outer bearing near the base of the fifth metatarsal, rising up and inwards to merge into the inner border of the anteroposterior arch. The roof of these arches is supported to some extent by the plantar fascia and some of the intrinsic muscles of the sole, but chiefly by the long and short plantar ligaments and by the tendons of the tibialis anticus, flexor longus digitorum, flexor longus hallucis, and especially as regards transverse spread by the peroneus longus. Most strain comes upon it during locomotion and it is just at this time that these muscles being in a state of contraction afford their most strenuous support.

Pathology.—When the muscles are inefficient and an undue strain is thrown upon the ligaments these yield and when the short plantar ligament fails the astragalus, the key-stone and crown of the great plantar arch slips downwards forwards and inwards, interposing itself between the scaphoid and the os calcis and permitting the scaphoid to descend and rotate outwards and with it valgus of the foot. The leg descends with the astragalus, the in-

ner malleolus rotates downwards and backwards, the outer malleolus forward and upward producing an alternation in the obliquity of the axis of flexion of the ankle joint. There is an exaggerated inward rotation of the thigh to compensate for the inward rotation of the leg. In the extreme grades flexibility is lost because of the lack of tonicity of the supination group and the spastic contraction of the pronation group. Inflammatory changes, fibrous adhesions and bony ankylosis of the joints may occur.

The prophylactic treatment consists in frequent inspection of the feet especially after long marches and the men be instructed to report any painful affections of the feet. These should be examined carefully and directions given for treatment. Especial care should be taken to see that the shoes are fitted properly. This is certainly a very difficult task with the present issue shoe. This seemed to be the consensus of opinion of those medical officers that I talked with at San Antonio, Texas, and Weed has found by a series of careful measurements that the issue shoe is too small (or flat) in front and too large back of the mid-tarsus. On long marches the marching strap of the French Army might be used to considerable advantage.

The treatment of slight degrees of flat foot is rest for a few days combined with slight support such as that afforded by a double-turn of an elastic-webbing bandage, (two and one-half inches wide and one yard long), taken in a figure of eight round the ankle, the second turn taken well forward and brought sharply up and fastened in front of the ankle. This will very often relieve the pain entirely. Adhesive straps can also be used for this purpose. The sensible principle is not to depend upon propping up the arch from below, leaving it at the same time to bear all its original burden, but to remove or diminish the weight that is breaking it down and to strengthen up the muscles upon whose integrity the arch depends. The patient must be taught to walk properly with the feet straight or very slightly turned outwards. After a few days rest, exercise the object of which is to strengthen the muscles that maintain the muscular balance of the arch, are prescribed. Smith suggests the following exercise to be taken at first once a day and after a few days to be taken twice a day:

1. Patient sitting, feet rest on heels and parallel, flex the toes three seconds then extend them the same length of time; do this twelve times.
2. Resistive circumduction of the ankle, commence with flexion, sweep the toes out and down to full extension, complete the circle by bringing toes up and inward, twelve times.

3. Heels parallel and slightly off the ground all the time, walk slowly around the room three or five minutes.

4 Feet turned slightly in, slowly rise on toes and return to ground; twelve times.

5. Feet parallel rise onto outer borders and walk slowly round the room three to five minutes.

6. Standing upright with toes slightly in, heels one inch off the ground, raise rapidly to two inches off the ground and return to original position. Six periods of fifteen seconds each.

The leg muscles should be massaged and bathed for five minutes afterwards. The shoes should receive careful inspection and if necessary increase the thickness of the inner side of the heel and extend it forward (the so-called triangular heel), and it may be advisable to put an additional patch on the inner side of the sole under the head of the first metatarsal. These shoes hold the foot in a slightly supinated position and transfers the greater part of the weight to the stronger outer portion of the foot.

In the pronated types where these measures are insufficient to raise the inner border of the foot variously designed foot plates may be used, the most valuable of which is the arch support designed by Whitman and shaped to fit the foot by means of plaster impressions of the individual foot. The exercises should be kept up while wearing this type of arch support and eventually we may be able to discard the arch support altogether. It is in this type of cases that we may have to forcibly over-correct the deformity and put the foot up in a plaster cast in the supinated position for eight or ten days, then begin the exercises and use the arch support if necessary.

In the rigid and inveterate types operative measures are necessary and the length of the convalescence and the improbability of a complete restoration of function so remote that the best interests of the service demands their discharge.

In capitulation we might say:

Flat foot seems to be responsible for a not inconsiderable amount of inefficiency in the Army and Navy and seems to be increasing rather than otherwise.

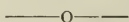
Treatment of mild and moderately severe cases can be satisfactorily carried out in the service and should be attempted in all but the very advanced types.

Especial attention should be directed to the condition of the feet of recruits while at the training station.

The lasts and specifications for the issue shoes should be in-

vestigated by medical and factory experts and a better fitting and a more comfortable shoe be devised and issued.

Medical officers should be instructed as to the details of treatment of these conditions and their attention called to their importance.



APPENDICITIS AND SOME OF ITS OBSCURITIES FOR THE SURGEON AND GENERAL PRACTITIONER.

DR. J. C. SHAW, Holton, Kansas.

Read before the Northeast Kansas Medical Society, October 24, 1912.

Probably no subject has received more attention or been more generally discussed in the past decade than a condition arising in the right iliac fossa due to the presence of the vestigial remains of a once functioning organ, but which with the advance of civilization in accordance with the law of use and disuse and in harmony with the modern idea of evolution, has come to a stage in which it is neither beneficial nor specially detrimental, and in this way it will remain through the time to come.

Some one has aptly put it—that it is an organ which gives the surgeon an excuse for something to do when the abdomen is open and he cannot find the cause for which he was looking; he can remove a poor innocent looking insignificant appendix and lay at its' door all the trouble which he could not explain; and, all the symptoms for which he could not account, and in this way it has become a great benefactor to the aspiring operator.

However, I would not offer this as a criticism, because I believe it can do no possible harm to scientifically remove an organ which has no physiological or functioning use, and which in a certain way is a constant menace to the individual.

In looking over the history of this trouble we find that many of the early writers describe a so-called disease, which so accurately agrees with appendicitis as to leave no doubt that it was the same as we now find it in our own general work. These cases had inflammation of the bowel and while many got well, just as they do now, yet a very much larger per cent died from their so-called bowel inflammation. And were they not correct in the final conclusion, for was it not inflammation of the bowel?

To quote from one of our older authors from a book published in 1772, he says: "This inflammation of the intestines is one of the most painful and dangerous diseases that mankind is liable to. It generally proceeds from the same cause as the inflamma-

tion of the stomach; to which may be added costiveness, worms, eating unripe fruits, or great quantities of nuts, drinking hard windy malt liquors, as stale bottled beer or ale, sour wine, cider, etc. It may likewise be occasioned by a rupture, by scirrhus tumors of the intestines, or by their opposite sides growing together.

The inflammation of the intestines is denominated iliac passion, enteritis, etc., according to the name of the parts affected.

The symptoms are nearly the same as in the foregoing disease, inflammation of the stomach; only the pain, if possible, is more acute, and is situated lower. Clammy sweats, with a small intermittent pulse, and a total cessation of pain, are signs of a mortification already begun and of approaching death.

Thus we see that, in a period so far remote, conditions were recognized and described which are convincing that our modern appendicitis was also a disease of earlier times or even antiquity. We also learn from the same author that their treatment will compare very favorably with ours, barring our surgical knowledge and procedure.

The simple non-complicated cases of appendicitis in adults, are comparatively easy, both as to diagnosis and as to operation, and will claim no special attention in my paper at this time. The symptoms in general in these cases are very much the same, and as the treatment is purely surgical, this will be passed over now. The non-surgical treatment varies very much, and we can reasonably expect much better results in the non-perforated types or the non-suppurative or gangrenous cases, from some lines of general treatment than from others. Also, in the preparatory treatment of those cases seen too late for an early operation or where seen early enough but refused operative treatment.

In children many of the catarrhal types are not diagnosed and a positive diagnosis may be impossible.

A simple and yet an almost positive sign is a palpable resistance of the right walls of the pelvis when palpated through the rectum.

Just what role the *bacillus coli communis* plays in the catarrhal recurrent non-perforated cases we don't know but that it is the prime if not the sole factor, once it gains access into the peritoneal cavity, is beyond dispute. It may, however, be associated with other pyogenic bacteria. The first great factor in these cases is the organ itself.

The English call the disease perityphlitis, from the Greek meaning around, blind and inflammation — inflam-

mation of the peritoneum surrounding the cecum. They claimed that the seat for the trouble is chiefly in the cecum itself, but later that the appendix played a dominant part.

Einhorn, as a result of a study of 18,000 post-mortem examinations, states that perityphlitis is of appendicular origin in 91% of the cases and that the remaining 9% are due to primary perforation of the cecum. Our own surgical experience would place the appendicular cases higher.

The type I specially desire to mention are the cases who make no reference whatever to the right iliac region, and when examined carefully by the physician he can detect little or no disturbance. These cases or at least many of them, complain of gastric disturbance or of chronic indigestion in general. They are nervous and irritable and many times complain of cardiopathies. As a rule, they sleep poorly, have headaches, and if females, nearly always have menstrual disorders. In fact, the large majority of these women have more or less menstrual disturbance. At times, they will have a normal period and then for four or five consecutive months have a recurrence of the appendicular irritation, due probably to continuity of the tissues or a remotely associated nerve supply.

A large portion of these subjects of chronic appendicitis are chronic dyspeptics. Especially is this true, if they are past twenty years of age. These cases also complain of tired aching feelings—most likely due to autogenous toxins.

The results of indigestion, fermentation, putrefaction and decomposition will most likely be accomplished by the absorption of toxic material from the whole alimentary canal. In the same way toxic substances are absorbed from the appendix itself. The fact that the digestion will become more and more impaired and that through this impaired digestion he is more susceptible to intercurrent diseases, makes his immunity lessened and his susceptibility to disease increased.

These cases soon become unfit to attend to the ordinary affairs of business and if in the employ of another soon be replaced by a more dependable employee.

We must look for the association or the relation of a chronically irritated appendix to remote conditions as a sequel, such as disturbance of the stomach, and resulting irritability of the heart, chronic indigestion, headaches, auto-toxemia and also the pelvic disturbances, which occur with such regularity in many women.

Constipation is not always the rule in these cases, but there may be at times troublesome diarrhoea. Then we may think of

tubercular peritonitis, and it might be quite well to do so, as an obscure case of this disease may very much simulate one of the unusual types of appendicitis.

In all these cases exploratory incision is justifiable, as it can do no harm and may be the source of a positive diagnosis and through this to a permanent cure.

SUMMARY.

First.—The disease we now call appendicitis was also a disease of antiquity.

Second.—The great cause of appendicitis is the appendix itself.

Third.—The simple uncomplicated cases are comparatively easy, both of diagnosis and of operation.

Fourth.—The treatment of non-operative cases is different and better results are to be expected under some lines of procedure than others.

Fifth.—Many cases of appendicitis do not have the classical symptoms, but have symptoms remote which lead the physician to believe the etiology something else.

Sixth.—Operation will do no harm in these cases and may be a great and lasting benefit.

—o—

PSYCHOTHERAPEUTICS.

DR. W. H. YOUNG, Fredonia, Kansas.

Read before the Wilson County Medical Society, December 10, 1912.

This term in its fullest sense includes any condition of the mind which may in any way affect the cure of disease.

It is a well known fact that no single organ of the body can be seriously impaired without evil effects being manifested on every other organ of that same body. This law holds good with the brain which is the seat of the mind. Any undue disturbance of the mind will thus to a certain extent interfere with the normal functions of the brain, and be the means of causing abnormal conditions to exist in other organs of the body. It is extremely doubtful whether any mental condition can advance to such a stage as to produce a permanent pathological lesion, but at any rate it is possible for a mental state to so interfere with normal organic functions as to prevent the removal of pathological conditions which could be effected with all the organs functioning normally. This fact gives the mental healer an imaginary basis for his false conclusion that all diseases are a result of abnormal

mental conditions. Knowing that a very large proportion of the chronic "grunters" have either diagnosed their own ailments or else been the victim of careless or ignorant diagnosticians, these "mental healers", "christian scientists", "vitopaths" and self-styled "specialists" on kidney troubles, catarrh and heart troubles have heralded the news of their mighty powers through the press to the people and a golden harvest has been reaped as a result. The purpose to be attained by all these imposters is to employ some method which will cause the minds of these victims to drift out of the old channels and lead them to think that they have been cured of some dreadful malady. The family physician who has plenty of patients who are actually sick, is too busy to give these mentally deranged victims the pretended attention which they receive from the quacks and the public hastily brands him as ignorant. The medical practitioner has held himself apart from this psychic work for so long that the public has come to think that he has no right to suggest that the patient should get "mind and body in harmony," or even intimate that the mind has anything to do with disease.

In fact, the average patient regards it as an insult when the family physician ventures any such statements and takes it that "Doc so and so" thinks there is nothing the matter with me and I am just puttin' it on."

But the learned "specialist" very carefully arranges matters so that a nice round sum is "deposited" in advance, and the victim cannot afford to take offense at anything the "specialist" may say to him for he knows full well that his money is gone forever and wants to get all he possibly can in return.

If the family physician dared demand his pay in advance, he then could come nearer accomplishing the same results. As it is, the general practitioner can only hope to apply his knowledge of psycho-therapeutics by doing it in such an adroit manner that the patient will not recognize the psychological part of the treatment.

In most instances this is referred to as the "confidence" which the patient has in the physician. Patients very often remark that they "have no confidence in Dr. so and so." This usually means that "Dr. so and so" has not yet demonstrated his ability to lead this person's mind out of its ordinary channels. These persons are unconsciously expecting psycho-therapeutics, but want it to come under the name of medical therapeutics.

The chief field of psycho-therapeutics in the general practitioner's work consists in preventing the occurrence of conditions

which will effect the mind of the patient, rather than in attempting to use suggestion for permanent effect.

The great revolution in the treatment of the insane in the last two centuries has been marvelous. Only 2000 years ago the theological and medical professions vied with each other on instituting torturous treatment for those who were of unsound mind. The insane man was considered a worthless wretch possessed with demons and it was public duty to inflict such cruelty upon him that these "devils" would be compelled to change their abiding place.

In this enlightened age, the world looks on these unfortunates as extreme objects of pity, and the person who fails to do everything possible to add to their peace and comfort is dealt with harshly.

Some of the cures effected among this class by kindness have been very gratifying.

In nervous troubles it is very customary for the physician to send the patient to health resorts where mental and physical quietude are enjoined. Many times this may be accomplished equally as well at home.

In acute fevers the question of mental quietude is of great importance, sad news, unexpected occurrences, or any undue excitement will hastily cause a rise in temperature accompanied by disastrous results.

In obstetrical practice every effort should be made to keep the expectant mother from "going to pieces." Mental uneasiness will always retard and sometimes prevent the progress of labor. By suggesting when to work and when to rest, the physician will in many instances be surprised at the completeness with which the labor pains may be brought under control. With the pains under good control, the agony of the mother is very greatly diminished and more effective work obtained.

In hysterical cases which so sorely perplex the doctor, the methods of meeting the psychic conditions are of various kinds. The old-fashioned way of using "cuss" words in the presence of the patient can hardly be recommended in this refined age. Liberal doses of the slightly diluted tincture of capsicum and lobelia compound will have a wonderful psychic effect on those supposedly unconscious cases to which the physician is sometimes called. This may seem a little radical at first thought, but after careful consideration one remembers that the actually unconscious patient will not know how hot the dose is; while the one who is only pretending to be unconscious will, like wives of old, soon call for someone to cool her tongue, and the hoax will be suddenly ended.

In this class of cases the surgical "grafter" uses a cruel, but many times, temporarily at least, a very effective plan. Only a few years ago the medical profession passed through the curetting stage. Many gynecologists did this operation indiscriminately. When the neurasthenic patient applied to these practitioners for treatment, she was assured that the only means of relief was curettement. Then came the anesthetization, dilation and accompanying steps connected with this procedure.

This served to direct the patients' mind from her imaginary ailments and gave her something to tell her female friends for several weeks. But after the novelty of the occurrence had worn off the former state of mind returned.

So many times was this plan adopted for the sole purpose of obtaining a good fee, and so frequently were the final results very unsatisfactory, that the reactionary effect was to bring the operation into disrepute. This was very unfortunate for the conscientious general practitioner as he was then scarcely able to persuade a patient to submit to a curettment when it was really demanded.

Then came the period of oophorectomies, hysterectomies and circumcision. These were at one time so popular that even in society circles a large organization of wombless women and fore-skin-less men would have been quite possible.

Next followed the age of appendectomies which to the grafter had the decided advantage of being applicable to members of both sexes. And let me here remark that not all the phinicky grunters belong to the female sex.

The grafter is always ready to be the first to adopt any new discovery and use it to promote his financial interests. Large hospitals have been built and maintained, surgeons made rich and patients robbed of the necessities of life as a result of the efforts of these grafters. And the sad part of the matter is that it has been done under the protecting cloak of the medical profession.

The fact that it takes much longer for recovery from abdominal operations was responsible for the longer periods of mental relief which followed. It sometimes takes a year or two for the abdominal scars to heal, all the soreness to subside, and the patient have ample time to tell a host of sympathizing friends the full history of the wonderful operation.

All this time the family physician plays second fiddle to the grafter's tune, sits quietly by and hears the great skill of some wonderful surgeon heralded to the skies. But after the usual period of time, (which often means temporary relief to the home physician) the reactionary effect comes and praise is followed by curses,

and the family physician, the only one accessible, is placed in the same class with the grafter and carries the whole load of abuse.

No doubt every medical man here present has had the experience of getting turned down when he recommended the actually needed appendectomy, and witnessed his patient pass on to a stage of the disease where surgery could offer no hope.

The late self-styled eminent specialist, Dr. Carson of The Temple of Health of Kansas City, had full knowledge of the fact that people like to have a disease which is popular; and that fully nine-tenths of the supposed cases of appendicitis are either self-diagnosed or have gone through the hands of an appendectomy grafter.

Here again the mental healing fakir bought whole pages in the newspapers and proclaimed to these unfortunate victims his wonderful power to heal all cases of appendicitis. They came by hundreds, paid their money, received some sooth-saying ceremony and went home with their minds much relieved.

After having passed the word to all friends and neighbors they gradually returned to the old mental state and like the surgical grafter's victim, came back to the old family physician for final relief.

This relief will never be received until the general practitioner devises some means of procedure which will enable him to retain the confidence of those patients and convince them that they have no real pathological disease and that the only thing to be cured is an abnormal condition of mind which can only be changed by their own efforts.

In many instances this as yet appears impossible to do. In some instances these imaginary ills may be traced to domestic troubles and home surroundings. Unless these causes can be discovered and removed, nothing can be accomplished.

—o—

PHYSIOLOGY AND PATHOLOGY OF THE PUERPERIUM.

DR. E. A. REEVES, Kansas City, Kansas.

Read before the Wyandotte County Medical Society, November 26, 1912.

The puerperium is that period of from four to eight weeks following confinement, required for the female organism to overcome the changes which took place during pregnancy and recover from the injuries received during labor, and has very aptly been termed "the fourth stage of labor."

During this time the process of involution takes place by which the uterus is changed from a thin-walled muscular sack

weighing about one thousand grams to a nearly solid organ weighing sixty grams.

During involution the capacity of the uterus is diminished over five hundred times. This process, though most pronounced in the uterus, also effects the ovaries, the broad and round ligaments, the cervix, vagina and vulva. These are all vitally concerned in the process we call involution.

During this process another very important change takes place; that of the establishment of lactation; where a large gland of the body that before has been dormant suddenly takes on marked activity and functionates to such an extent that the daily secretion amounts to three or four pints, during which the mammary glands become congested, tense and hard, painful to the touch and by their own weight. There is often languor, lassitude, with slight rise of temperature, bordering very closely on the pathological.

And besides these there is always more or less injury to the birth canal, both the many openings for the entrance of micro-organisms, inertia of the intestines, due to decrease in the inter-abdominal pressure and sometimes paralysis of the bladder requiring catheterization three or four times during each twenty-four hours.

When we consider the many dangers through which each woman passes during her puerperium, we are constrained to believe that many a one owes her life to this time more to a kind Providence than to her medical attendant.

It is an indictment against the profession that our theories of mid-wifery are far in advance of our practice, and should the surgeon be as careless of the modern technique of his calling as the average physician is in his obstetric practice he would be ostracised by his professional brethren and branded as a quack.

The opinion of the laity that "just anybody" is alright for obstetric work is shared by not a few of the medical profession. We teach and know that the vulvar toilet should be made in an aseptic manner and the pads for the vulva prepared with sterile hands from sterile material, but how many of us take the pains to see that it is so done? How many of us have found on the second or third day our puerperal patients lying on an old dirty quilt using some of the soiled family clothing, colored rags or soiled towels for napkins.

It is the physician's duty to guard carefully through this perilous period all those who entrust themselves to his care and he alone knows and understands the dangers and the dreadful penalty often attached to carelessness at this time.

Penalties of sepsis, hemorrhage, pus-tubes, prolapses, displacements, etc., often resulting in invalidism or serious surgical operations later to preserve life.

The puerperal patient should be kept quietly in bed for at least eight or ten days, depending on the strength of the patient and rapidity of involution, with light nourishing diet, bladder should be emptied at the furthest in twenty hours, by catheterization if need be, bowels should move freely not later than the third day, breasts and nipples cared for in an aseptic manner by bathing nipples with a saturated solution of boric acid, after each nursing followed by sterile olive oil if the nipples show a tendency to crack.

As infection is the one thing most to be feared we should as far as possible close all tears in the vagina and perineum, to assist in their healing and keep out micro-organisms. Keep the uterus firmly contracted by the use of ergot, strychnine, quinine, etc., which also act as a stimulant and helps the patient to rally from her weakened condition brought on by labor.

She should have plenty of nourishing food and little or no company the first week, should get up gradually and not be on her feet for two weeks or assume her place in the home for from four to six weeks.

If thus cared for few of our patients will have any serious complications arising during the puerperium.

While we are considering the special dangers to which the child-bearing woman is exposed, we must not forget that she is liable to any of the diseases of mankind and is much more susceptible to many of them on account of her condition.

Let us now consider some of the conditions that may complicate the puerperium: Thrombosis of the veins of the lower extremities is usually a direct extension of the thrombotic process from the uterine sinuses and is usually septic, but may be purely mechanical, the infection causing a phlebitis or a periphlebitis.

The symptoms are not usually manifested until the second week, when there is some pain along the course of the large veins, slight rise of temperature, swelling of the limb and oedema.

Ordinarily only one side is affected but it may be bilateral. The swelling subsides slowly and it may be months before the limb is normal again. These patients should be kept in a horizontal position until all pain and fever are gone and then cautioned against too vigorous exercise.

Should this thrombosis become infected the patient is exposed to the dangers of infected emboli and pyemia.

Occasionally we get severe uterine hemorrhage during the puerperium caused by the retention of some of the secundines or the woman getting on her feet too soon. The treatment is of course to remove the cause and treat symptoms as they arise.

Vulvar or vaginal haematoma are of not infrequent occurrence and demand the physicians' attention during the first week following labor. If of small size they are usually absorbed if kept free from infection, as has been the case in the three or four cases I have seen. But if of large size with continued hemorrhage and anemia it may become necessary to incise the tumor, remove the blood clot and pack with gauze, great care being used to prevent infection.

Another very annoying complication to both patient and physician, is mastitis with mammary abscess. This condition will sometimes arise in spite of the physician's orders or the nurses' care. There will be pain and heat in the breasts, chill with high fever, headache and all the symptoms of acute infection.

As soon as the presence of pus can be determined it must be evacuated by free incision and drainage, taking care to cut outside the pigmented area around the nipple, and let the incision run as nearly as possible parallel with the milk ducts. The symptoms usually subside promptly following free incision, but these abscesses discharge for from one to five weeks with maybe a lacteal fistula for sometimes longer. About 8% of all cases of insanity in women have their origin in the childbearing process, about one in four hundred or $\frac{1}{4}$ of one per cent of all the women confined become insane. About two-thirds of these recover their reason in from two to three months, of the other one-third 2% to 10% die of sepsis or exhaustion and the balance remain permanently insane. The exciting cause is usually some profound emotion, as fear of some impending danger, illegitimate pregnancy, the grief of a deserted woman, profuse hemorrhage, sepsis, etc. These patients can be treated successfully only in an asylum.

Another condition sometimes arising during the second week of the puerperium has been of considerable interest to me because I have had two quite severe cases recently. That is traumatic neuritis of the genito-crural and sacro-sciatic nerves following difficult forceps deliveries. One of these was after a high forceps case in the R. O. P. position and was unilateral on the right side. There was almost complete paralysis of the right limb with numbness for several days followed by the most intense pain which lasted for nearly two weeks and then gradually subsided, but the patient was not able to walk for about two months.

The other was the delivery with considerable difficulty a small primipera, twenty-seven years old with small flat pelvis, not a very large child but a very small vagina and vulva. There was considerable injury to the soft parts which was repaired at once and healed beautifully by first intention.

The patient did nicely for the first week, no rise of temperature or other signs of sepsis. The child being still-born there was some tenderness and congestion of the breasts for a day or two but cleared up promptly under appropriate treatment. There was also some nervousness as she grieved sorely for her baby.

No catheterization was necessary as the bladder was emptied voluntarily at all times. There was considerable numbness of the lower limbs from the first but not more than is often the case in difficult deliveries. About the eighth or tenth day there developed a good deal of pain along the course of both nerves mentioned, with very marked tenderness to the touch. The suffering increased in intensity until she got no rest day or night and would cry out with the pain which it seemed nothing would relieve.

I gave her ten grains of aspirin every three or four hours, as much as a grain of morphine during a night, bromides, chloral and trional were given in heroic doses in a effort to give her some rest.

In the meantime the patient was becoming exhausted from lack of sleep and nourishment which she persistently refused.

The only thing that ever gave any relief to speak of was twenty-four grains of trional given in twelve grain doses one hour apart and a half-grain of morphine, which would usually give her two to four hours of troubled sleep. We used every kind of anodyne liniment we ever heard of, and one kind of patent liniment that never was known to fail before, hot baths by the hour, to no avail.

In about three weeks the pain all went below the knee and not quite so severe. This patient gradually improved and now after nine weeks, she can sit up in a chair usually rests fairly well at night, appetite good, anemia improving, but the bottoms of her feet are as tender as can be; she does not attempt to put her feet to the floor and there is considerable flexion of the leg upon the thigh. What will the outcome be?

The books say very little about these cases and attribute them to pelvic infection but in neither of these cases was there the slightest indication of sepsis.

DIFFERENTIATION OF SYMPTOMS LOCATED IN THE EPI-GASTRIUM.

E. E. HUBBARD, M. D., Kansas City, Mo.

Read before the Northeast Kansas Medical Society, October 24, 1912.

Diagnosis is the first great effort of the real practitioner and differentiation is a large part of the science of diagnosis. When we meet with complaints of pain or discomfort in the epigastrium, or a history of difficult digestion we are just beginning to understand that it probably means organic trouble with some of the viscera in the upper abdomen.

We must take into account, the gall-bladder, duodenum, stomach and pancreas, as presenting organic lesions here, and the appendix as presenting a reflex neurosis, besides gastralgia and intestinal colic which we must consider as functional. It is important to think of the gall-bladder first because it is more frequently in trouble, perhaps ten to one more than any other, and must be eliminated before we can go farther.

The old idea that there must be jaundice to indicate gall-bladder trouble has long ago been abandoned; although we occasionally see it when there is an occlusion of the common or hepatic duct and this may occur from any of the several causes outside the gall-bladder. There may be gall-stones in the gall-bladder and common duct and have no jaundice. The various possibilities of duct occlusion other than gall-stones are, tumor in the vicinity of the common or hepatic duct, pancreatic calculus in the ampulla of Vater, possible inflammation from ulcer and adhesions about the duodenum; also possibly inflammatory or other tumor of the pancreas. Thus making it reasonably easy to arrive at a general idea of the cause of jaundice quickly; but precision is attained only by elimination or operation.

Cholelithiasis or cholecystitis may exist for an indefinite time without attracting the patient's attention to the extent of driving them to the physician for advice.

Mayo tells us that innocent gall-stones are a myth for they always produce symptoms, and that it is the doctor who does not discover them who is innocent.

I am only a partial convert to this idea, but believe that history and examination will generally disclose the facts. History will reveal previous attacks of severe pain over the epigastric region, which soon confines itself to the gall-bladder area. This pain will appear suddenly and will be distinctly paroxysmal; it

will generally appear at night, probably not affected by digestion, and will radiate to the back and shoulder, leaving a tender gall-bladder area and tense rectus muscle. In cholecystitis the pain will be more continuous than in cases of stone.

Some degree of chronic indigestion will always be a part of the history and perhaps a large part. If there is bile retention there will be jaundice, clay colored stools and constipation, and the urine will contain bile.

Kehr thinks the history is a better guide than physical findings. He says that in 4000 cases he was able to palpate stones but three or four times.

A possible antecedent history of gall-stones and cystitis may be a good point to note. It is known that many cases of cholelithiasis and cholecystitis give history of having had typhoid fever, and it is conceded that infection probably does not enter the gall-bladder from the duodenum, but from the portal circulation, by way of the bile ducts, and come to the gall-bladder in the bile stream by a retrograde process from the hepatic and common duct.

With these points in view we can easily presume that infectious diseases may always be the fore-runners of gall-stones or cystitis and that perhaps we always have a cystitis in these cases and that in the great majority there is a voluntary abatement of the inflammation.

We may just as reasonably presume that chronic constipation is a possible prolific cause of cholelithiasis and cholecystitis for the above reason, viz., that the entire portal circulation is emptied into the liver and the filtering process retains all the refuse to be eliminated with the bile.

It has been noticed that chronic appendicitis seems really to be the cause of gall-bladder trouble at times. This suggests the perennial question: "The cause of appendicitis." We already know the ileo-caecal region is the location most infected with bacteria, and 85% of tuberculosis lesions of the alimentary tract appears here. Is it any wonder that any and all lesions are frequent at this site? It is wonderful that the blood might carry infection to the liver and that it might lodge in the gall-bladder and that the ducts being infected first, carry by way of their lymphatics, infection to the pancreas, stomach and duodenum?

All who have opportunity to notice observe that women are much more prone to gall-bladder trouble than men, Mayo says more than three to one.

In view of remarks about constipation I am reminded of a

jocular definition of women given some years ago by Goodell. I think it was, to the effect that "Woman is a constipated animal with a headache." I will also repeat a hobby of my own which is, 'if we could keep our elimination up to par we might live as long as trees.'

Indigestion with or without pain especially after eating meat in the absence of emaciation and jaundice as a reasonable cause for suspecting gall-stones of large size in the opinion of Leilienthal. Leilienthal's typical gall-stone patient is a woman in the early forties, who is rapidly gaining flesh, who eats inordinately, bolts her food and is careless about her bowels.

With the possible addition of a nervous disposition with frequent emotional crises we think the picture pretty near complete.

Runyan of Little Rock, suggests that advancing age, and I will add vitiated nerve function, produce atrophy of muscles about the biliary apparatus, thereby producing stagnation by the loss of peristalsis.

Litchy says that gastric analyses indicate a hyperacidity in only about 53% of gall-bladder cases, and gastric motility is disturbed and about the same proportion. Temperature is seldom disturbed enough to be of use, for even in empyema the temperature remains in the normal range in 50% of cases. This can be explained by the absence of lymphatics in the wall of the gall-bladder, there being no absorption from the gall-bladder proper.

The bladder wall may be distended to such an extent that the duct is also partly dilated and then we get into the region of lymphatics canals and nodes; by this means we get absorption and fever in some cases.

Cholecystitis must be considered here to make connection complete. Etiology of cholecystitis must be conjectural in some cases, but we know it is sometimes associated with stones, and as above stated may always be associated with infectious diseases and the exanthemata, as all kinds of bacteria have been found in the gall-bladder.

Symptoms in acute cases are sudden, violent onset of pain, sharp and paroxysmal in the region of the gall-bladder or epigastrium, remittent in character, at first diffuse, later localized, associated with great tenderness and muscle rigidity, nausea, vomiting and prostration. Pulse is usually rapid; temperature generally high; chill may occur immediately or later; jaundice not present. Tumor is usually absent but when present is smooth, symmetrical, tender, tense, non-fluctuating. Tympany in fulminating cases. Constipation absolute.

This may be hard to separate from acute pancreatitis but we can easily surmise from the foregoing that infection may be carried from this region to the pancreas.

Deaver believes that the lymphatics which lead from this area to the pancreatic area are the carriers of a large part of the infection. He also believes that arterio-sclerosis, tuberculosis, syphilis and alcohol play their part in producing pathologic conditions of the pancreas, but they are hard to estimate and rather ultra for diagnostic purposes. In a large number of cases a calculus from either the gall-bladder or pancreas itself is found in the ampulla of Vater, obstructing the entrance to the duodenum and damming both bile and pancreatic secretions back into the duct of Wirsung, thereby producing the irritation and the accompanying hyperemia consequent on its presence, as well as the erosion produced by the pancreatic secretion. This combination is practically sure to produce hemorrhagic pancreatitis. Any process that will prevent drainage and assist in damming back any infections or irritating material into the pancreas will produce pancreatitis. Various symptoms of soreness, indifferent digestion, pain and even tumor in front are possible in pancreatitis, but are common to almost any other trouble in this quarter.

Deaver acknowledges that we know of no pathognomonic signs or set of symptoms for pancreatitis. He says that the physician or surgeon who encourages his patient in the belief that he will surely solve the problem is either a commercial gentleman, a knave, or is without knowledge.

The stools seem at times to be characteristic, being voluminous and fatty, frequently showing fat globules on the surface, of a grayish color, and containing undigested muscle fibres at times. It was originally supposed that glycosuria was necessarily present in disease of the pancreas, but this is in reality seldom found.

The Cammidge reaction might be mentioned, but on severe general trial it has proven simply foolish.

The Fuld-Gross-Goldschmidt and the Wolgemuth tests are sources of information but are only confirmatory.

In the enumeration of symptoms, pain will take a leading place as the most constant and characteristic sign. Onset is sudden and violent, more so than in other conditions, accompanied by shock, toxemia, lividity, rapid pulse and shallow breathing, may have exacerbations but no remissions, located in left hypochondrium and thorax. Jaundice is seldom seen but when present is constant and intensifying, vomiting more or less con-

stant, urine usually negative, but may contain sugar, hiccough may precede and follow attacks. Temperature is sub-normal, rapidly rising above.

Gall-bladder cases show no temperature except in suppurative cases. Loss in weight may be as great in gall-bladder disease as in malignancy or pancreatitis.

Tenderness is deep in epigastrium and left hypochondrium. Tumor is not frequent, but when present is in epigastrium or left hypochondrium. Ascites may develop early from hemorrhage or inflammatory exudate. The symptoms which will follow these manifestations are those of ordinary peritonitis, as abdominal distention, obstruction, due possibly to pancreatic enlargement or intestinal paresis.

We may now pass to the consideration of ulcer of the stomach and duodenum. I will try to discuss this by contrast. We were taught as lately as 15 years ago, or less, that duodenal ulcer was a rarity and caused largely by external burns; but in the past few years we have begun to realize that duodenal ulcer is frequent, and more common than gastric ulcer. Mayo's statistics indicate that there are 20% more ulcers in the duodenum than in the stomach; making it necessary that we always consider duodenal ulcer in any trouble in the upper abdomen. Clinical history is probably the best means of recognizing duodenal or gastric ulcer. Pain is the important diagnostic symptom.

This must be in the upper abdomen at the tip of the ensiform process, or at near the middle line, passing through to the back at one or the other side of the spine, becoming as tender behind as in front at times. History will show that this pain has been manifesting itself in recurring attacks over a period of months or years, and most likely the latter, perhaps ten or fifteen years or more.

The pain is not as severe as in hepatic or renal colic and is not colicky and intermittent in character like these, it is more of an aching or stabbing, but generally endurable. These attacks are called "wind colic" "acute indigestion", "bad spells," etc., and their regularity is very irregular; once in several days, a month or two or a year or two. One characteristic of this pain is its relation to meals, which is three or more hours after meals, midnight or after being a favorite time for an attack, but they may come late after the other meals, as hunger begins to be felt. Spoken of as hunger pains. The attacks vary in duration according to treatment, from one to several hours and do not begin or stop suddenly. Relief may be had in several ways, by taking food, bicarbonate of soda, or drinking large draughts of water. Heat

is very helpful. There is no nausea in uncomplicated duodenal ulcer, no vomiting and no sweating; the appetite, digestion and health are as good as ever, although there may be slight sour stomach, gas and belching, but no serious indigestion. When any of these occur there is a probable complication or it may be some other condition. In the matter of chemistry there is usually hyperchlorhydria following a test meal. Moynihan says that recurrent hyperchlorhydria is duodenal ulcer, but this will not hold water because duodenal ulcer is met with in cases where there is no hyperacidity. Physical examination after an attack reveals nothing but soreness. I am inclined to give little credence to the results of a test meal in the matter of hyperacidity because we hear hyperacidity preached for nearly all the conditions in the upper abdomen. It is my opinion that any reasonably normal stomach will show a hyperacidity after a small "snack" like a test meal, because the stomach has been accustomed to secreting a given amount of digestive material for each meal, and when this "tacet" of a meal is digested there is left over a surplus of digestive material to look wise about.

In an article entitled "A Clinical Study of a Thousand Cases of Gastric and Duodenal Ulcers," in American Journal of medical Sciences, Fredenwald says that 7.8% of patients suffering from various gastric disturbances are affected with ulcers, the latter occurring between the twentieth and fiftieth year. there being two males to one female, in gastric ulcer, anaemia is present in a large percentage; about half over-eat, normal acidity is present in forty-six per cent; hyperacidity in thirty per cent, and sub-acidity in twenty-three per cent. Males are given to hyperacidity females to subacidity. The acidity is very high in recent ulcers, especially when preceded by recent hemorrhages, while chronic cases show low acidity. The duration of symptoms average 12 years; the prominent symptom being pain, which occurs in 90%. Pain occurring immediately after food marks gastric ulcer, when long after food, means duodenal ulcer. All symptoms may be absent for many months, 90% have an epigastric tender spot, 32% have a dorsal tender area; 67% vomit; 22% have hematemesis; 52% are duodenal ulcers; 40% gastric ulcer; 48% of duodenal ulcer show normal acidity; 35% hyperacidity; and 16% subacidity. See don'ts by G. R. Lockwood at end of article.

Pain is present in 96.5% of duodenal ulcers, most severe in cases of hyperacidity. Melena is present is 54%, occult blood in stools in 83%. He claims that a diagnosis of ulcer should not be made unless occult blood is found in the stools.

Gastric and duodenal ulcer are not often coincident. Mayo claims 8.2% in his cases, while Moynihan reports 47 coincident occurrences in 186 cases. The coincidence of gastric and duodenal ulcer must confuse the symptoms and keep us mindful of this fact in arriving at conclusions. Duodenal stenosis may result from cicatricial contraction of the base of the ulcer in chronic cases and then we have stagnation of stomach contents, regurgitation and dilatation, all of which will follow gastric ulcer with pyloric involvement of the same sort.

The early history before stenosis is the only means by which differentiation may be made. Hemorrhage is a late complication in duodenal ulcer and produces a typical picture of faintness even to unconsciousness, pallor and sweating, followed later by tarry stringy stools. Occult blood may be found in stools during entire active part of process in duodenal ulcer, but practically never in gastric contents. Perforation of the ulcer is unexpected and is usually late, all of the former history having gone before, yet this may be the first incident that has alarmed the patient. The symptoms of either gastric or duodenal perforation are very similar in the early part of the attack, which is agonizing pain in the upper abdomen with faintness, cold sweats, rapid respiration, pallor, rigid and very tender abdomen. The immediate requirement being operation.

Chronic duodenal ulcer is not easily differentiated from gastric ulcer and cholelithiasis. I will detail the signs of gastric ulcer in contrast to duodenal ulcer.

All have been satisfied for years to be able to diagnose an ulcer; caring little whether it was above or below the pyloric ring, allowing operative inspection to settle the question; and yet it is possible to make a reasonably accurate localization of the lesion before operation.

Both conditions give a history of attacks of pain in the epigastrium extending over long periods of time, but in gastric ulcer dyspepsia is more or less constantly present, between attacks, as "sour stomach," "water brash," "nausea," etc., nutrition being more or less continuously disturbed. The attacks and the pain and its radiation are practically the same in each, but the difference in time of the pains is characteristic, it being soon after taking food in gastric ulcer, within two hours pain almost causing nausea and vomiting, thereby removing the cause and bringing relief, gastric disturbance is more constant at, and between attacks in gastric ulcer, than in duodenal ulcer.

Physical examination may show more disturbance in gas-

tric ulcer, a succussion splash several hours after taking food, showing dilatation, a peristaltic wave across the stomach wall, a tender area at site of pain and a rigid rectus. These are all in contrast to duodenal signs. Occult blood is frequent with a test meal in gastric ulcer but practically never found when the trouble is below the pylorus.

The gold bucket and silk thread tests are useful but not practical to the general diagnostician. Gastric ulcer may produce hemorrhage as a complication, but it is vomited, while in duodenal ulcer it passes out largely in the stool.

Some of the gastric hemorrhage will escape by the bowel, producing melena as in duodenal hemorrhage.

Epigastric tenderness and a tender spot at the left of the 11th or 12th dorsal vertebra indicate gastric ulcer.

The relation of the appendix to epigastric trouble will naturally be the next subject under consideration. While there seems to be no system to be followed there certainly is a connection between the appendix and the viscera in the upper abdomen. It seems good logic to me to suppose that the argument in favor of the bacterial flora in the ilio-caecal region causing appendicitis is good, except in cases caused by a foreign body. The portal drainage carrying myriads of bacteria to the liver, all of which perhaps dumped into the bile stream, and at least pass by the door of the gall-bladder, pancreas, and stomach into the duodenum is cause enough for all of the phenomena noticed in the epigastrium, besides the necessarily direct communication by way of sympathetic nerves in the coats of the blood vessels, and possible lymphatic drainage in this direction. There must be some ever present cause at work to produce appendicitis at the rate of one death in every 50, and 1-5 to $\frac{1}{4}$ of all the operations done in hospitals. In the matter of clinical symptoms of appendicitis manifesting themselves in the epigastrium, we know that an acute attack usually manifests itself by severe abdominal pain, producing nausea and vomiting with some degree of shock, especially in cases that perforate; all acute symptoms subsiding in a day or so leaving a mere soreness at McBurney's point, or evidence of peritonitis. The chronic cases being very insidious, produce much less clearly marked symptoms, and we find cases going the round of doctors, and sanatoria trying to find a remedy for auto-infection, headache, backache, dysmenorrhoea, frequent urination, irregular heart, soreness in the lower part of the stomach, neuralgia of the bowels, bilious colic, wind colic, constipation, diarrhoea, dyspepsia, nausea, anorexia, gastric and intestinal in-

digestion. The foregoing symptoms recorded as symptoms of appendicitis make the diagnosis seem very far-fetched, and that it should be missed frequently is not surprising; especially since cholecystitis may be mistaken for appendicitis. Pain in appendicitis may be under the liver and in cholecystitis it may be in the right iliac region and tenderness be over McBurney's point.

I have forgotten until now to mention the X-rays in the diagnosis and differentiation of ulcers, but will leave that for the discussion, although it is very important and useful.

I will quote eleven "don'ts" from a paper by G. R. Lockwood, in N. Y. State Medical Journal, entitled "Hyperacidity." (Abbreviations mine.)

1. Don't make a diagnosis of hyperacidity until all organic lesions are excluded, and even then prepared with a free and unbiased mind, to change the diagnosis to one that is more definite and distinctive, should other physical signs arise.

2. Don't make the diagnosis of hyperacidity without examination of the stomach by a tube. The presence of acid fluid or of food remains, or of any considerable amount of gastric mucus should exclude the diagnosis.

3. Don't make the diagnosis of hyperacidity simply because the patient is nervous and neurasthenic.

4. Don't make the diagnosis of hyperacidity should the previous clinical history suggest attacks that may point to appendicular or gall-bladder disease or should the physical examination suggest that these lesions are probable.

5. Don't make the diagnosis of hyperacidity accompanied by epigastric pain. Especially should this diagnosis be avoided if the pains occur at a stated and regular time after eating.

6. Don't make a diagnosis of hyperacidity if hemorrhage is present, either visible or occult, in vomited matter or in the stools. Examination for occult blood in the stools should never be neglected.

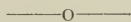
7. Don't make the diagnosis of hyperacidity in cases with repeated vomiting, especially if vomiting be of the abundant acid fluid indicative of hypersecretion.

8. Don't make the diagnosis of hyperacidity if the symptoms occur when the stomach is empty.

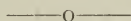
9. Don't make the diagnosis of hyperacidity in the event of the test breakfast settling into two layers, the supernatant fluid layer being twice or more the depth of the underlying sedimentary layer. These are cases of alimentary hypersecretion and not of pure hyperacidity.

10. Don't make the diagnosis of hyperacidity in cases attended by loss of appetite or by nausea or by advancing anemia or by loss of weight especially if the patient be of adult years, with or without a previously good digestion.

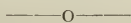
11. Don't make the diagnosis of hyperacidity without mental reservation in those over 45 years who complain of this disorder for the first time.



Feeding in Post-Operative Acidosis.—Acting on the assumption that post-anesthetic vomiting called for an interdiction of food, we heightened the degree of this acid intoxication by further starvation. Or if we did give food, it was of such a nature that it was poorly calculated to combat the development of acid intoxication. We gave beef tea or malted milk when we should have used carbohydrates, such as baked potatoes, cornstarch pudding or mush. I have often seen post-operative vomiting which had resisted all palliative measures cease immediately after the giving of these substantial starches.—S. T. Pope, in the J. A. M. A.



A Disguise for Castor Oil.—Put into a tumbler about two ounces of strong lemonade, using nearly half a lemon. Pour in the desired quantity of castor oil. Just as you are ready to give it stir in about one-quarter teaspoonful of baking soda. It will foam to the top of the glass. Have the patient drink it while it is effervescing. Even the oiliness of the dose is not detected.—Ex.



Diagnosis of Brain Abscess.—The diagnosis of brain abscess is to be made (like other intracranial conditions) by study of the signs and symptoms which result from its presence; in addition, a history of trauma, bronchiectasis, empyema, etc., will prove helpful; while last, but by no means least, a study of the blood for the conventional changes due to existing suppuration should be made. If the abscess is within the cortex, or enveloped by the meninges, changes of the cerebrospinal fluid (i. e., lymphocytosis, increased serum-albumins, microorganisms, pus, etc.) may be anticipated. If the abscess be of sufficient size to alter the intracranial tension, a choked disk may be manifested; or, if not quite sufficient to cause this phenomenon, a prechoked disk may be in evidence.—N. W. Sharpe in the Journal of the Missouri State Medical Association.

THE JOURNAL OF THE Kansas Medical Society.

JAMES W. MAY, - - - - **EDITOR.**

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

The January meeting of the Council will be held at Topeka, January 16th in place of January 10th, announced in the December issue. The meeting will be held in Dr. W. E. McVey's office.

—o—

The Kansas City Star has been running a series of articles entitled "Confessions of a Quack." These articles exposing quackery in many of its forms were written by a man who had been in the quack medical business for seventeen years and knew whereof he spoke. The Star is to be commended for the stand it has taken and it can rest assured that there will be great good follow its wake.

The profession of Kansas is duly grateful.

—o—

The annual dues to your county society are due and should be paid now. The payment of your dues to your county society keeps you in good standing in the State society with its many advantages, viz., the state Journal, medical defense and many others. PAY UP.

—o—

An example of what a good live secretary can do for a medical society has been aptly proven in Wyandotte County. At the

time the present secretary, Dr. J. F. Hassig entered upon his initial term, January 1, 1912, the society was suffering from lassitude anorexia and various other maladies. There was considerable pulling and hauling, antagonisms, jealousies and withal, poorly attended meetings. It was difficult to get up a program on account of the lack of interest. The membership was about forty-five. Behold the transformation!—One of his first acts was to increase the membership which at the last meeting in December, reached one hundred, (paid up), the largest by far of any county society in the state. There are now not more than six or seven doctors in the county who are eligible, who do not belong. This was followed by highly interesting programs, which included symposia, papers on selected subjects, reports of clinical cases and interesting discussions. The feeling of antagonism and jealousy have disappeared and now Wyandotte County has a body of men who meet every two weeks and give their ideas and experience to the benefit of all. Dr. Hassig has been ably assisted by the President, Dr. Geo. M. Gray, who has attended every meeting except one and then being absent only on account of sickness. The society unanimously re-elected Dr. Hassig secretary for 1913. Would that there were more secretaries like him.

—o—

It seems to me that Dr. McVey incubated a brilliant idea when he suggested getting noted specialists from various parts of the country to deliver addresses at our state meeting, and thus have as he said a medical chautauqua. We have been trying for years to stimulate interest in the state meetings, and it would seem that this plan would be a very good one to try out. We could bring to Topeka the best in the profession and have two days of lectures which would be in reality a post-graduate course. The old plan has been used until most of us are tired of it and a change for this year at least would be welcomed by nearly every one. The attendance is good usually, but it very frequently happens that only a handful really are present to hear the papers. It is not through any disrespect or on account of the papers not being worthy, but on account of lack of interest. This plan will be discussed at the councillors meeting in January and more should speak on the subject.

C. S. K.

—o—

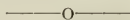
EDITORIAL CLIPPINGS.

PREVALENCE OF THE HEROIN HABIT.

Heroin, which is derived from morphin, is so frequently em-

ployed in the treatment of various diseases that the question of formation of habit from its use is a serious one.. It is often prescribed for cough, the result of irritating conditions in the air-passages, and physicians not infrequently tell their patients what drug they are prescribing, so that indirectly the patient comes to look on heroin as a harmless remedy for his cough. Even physicians are not sufficiently alive to the danger of habit from its use. In one instance a patient told a physician, who was called to treat him for an attack of laryngitis, not to give him anything that contained opium, for he had formerly been a slave to this drug. The physician replied: "I will give you some heroin; there is no danger of habit from that." This the patient took, with the result that he later had as much difficulty in breaking away from the heroin as from the opium habit.

Some patients who are addicted to the use of morphin substitute heroin because it is easier to obtain. A further reason for the use of heroin is that firms advertising preparations containing this opium derivative call attention to its harmlessness. In a recent issue of *The Journal of the American Medical Association*, Dr. John Philips, of Cleveland calls attention to the fact that heroin is being used extensively by means of "snuffing," in the tenderloin districts of large cities. One patient said that he knew at least twenty of his associates who used the drug in this manner. The dangers of this practice should be known as the heroin habit is just as bad as the morphin habit.



SCIENCE AN ICONOCLAST.

We recently commented on the part imagination has played in scientific advancement. Instances were quoted in which the metaphors of early writers have become established as facts by science. Sometimes the foreshadowing may seem almost prophetic; no doubt it is often mere accident. Science hews to the line no matter where the chips may fall. Often an idol of the earlier epochs of thought is shattered. Thus we sought to avoid "colds" by avoiding all contact with cool fresh air. Now, he who seeks to avoid infection of the respiratory tract wears light clothing and breathes air fresh from the open. A generation ago calomel was given to stir up the liver and increase the flow of bile. Now pharmacologists agree that whatever virtues calomel may possess it is not a cholagogue. When we were boys candy and sweets were withheld from us as things productive of many serious derangements. Now pediatricians allow plenty of sweets as an essential part of the diet for children. Not long ago we were

taught to avoid drinking water with meals, as the excess of fluid diluted the digestive juices and hindered digestion. Now it seems to have been demonstrated that water taken with meals aids digestion and facilitates absorption. And so it goes.

SOCIETY NOTES.

2nd District, Dr. C. C. Goddard, councillor, Leavenworth:

The Northeast Kansas Medical Society will hold its next meeting at Kansas City, February 13, 1913. The meeting will be held at the Mercantile Club Rooms. A dinner will be tendered the visitors at the Grund Hotel by the Wyandotte County Medical Society. The officers of the society are: Dr. Hugh Wilkinson, president; Dr. L. V. Sams, vice-president; Dr. C. C. Goddard, secretary. The following interesting program has been arranged:

1. Kidney Stone, C. J. McGee, Leavenworth.
2. L. V. Sams, Topeka, Paper.
3. A Short Detour Outside the Beaten Path, Noah Hayes, Seneca.
4. W. M. Mills, Topeka, Paper.
5. Exophthalmic Goitre, S. S. Glasscock, Kansas City.
6. Medical Clinic, P. T. Bohan, Kansas City.
7. Sinusitis, C. L. Zugg, Kansas City.
8. Blood Pressure, S. U. Gillespie, Lawrence.
9. Pain, J. L. Chambers, Lawrence.
10. Vesical Calculus and Other Pathological Conditions of the Bladder, M. T. Sudler, Lawrence.
11. Recent Advances in Regard to and Knowledge of the Anatomic System, John Sundwall, Lawrence.

On account of the length of the program the meeting will commence at 9:30 A. M.

At the annual meeting of the Wyandotte County Medical Society the following officers were elected for the ensuing year:

President, W. F. Fairbanks.

Vice-president, C. J. Lidikay.

Secretary, J. F. Hassig, re-elected.

Treasurer, Thomas Richmond, re-elected.

Censor, C. L. Zugg.

Delegates to the State Society.—J. E. Sawtell, J. F. Hassig, Preston Sterrett, James W. May.

3rd District, Dr. Hugh B. Caffey:

The Crawford county medical society held its annual meeting

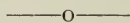
on the evening of December 6th. in the private dining room of the Stilwell Hotel in Pittsburg. Dinner was served at seven o'clock, after which Dr. G. W. Traylor read a paper on Gastric Ulcer. Election of officers resulted as follows:

President, Dr. A. O. Blair, Pittsburg.

Vice-president, Dr. G. W. Traylor, McCune.

Secretary-Treasurer, Dr. C. Mart Montee, Pittsburg.

Dr. H. H. Bogle Pittsburg, was elected a member of the the Board of Censors and Dr. C. R. Tinder of Arcadia delegate to the state society.



The Wilson County Medical Society met at Fredonia, Tuesday, December 10th.

Election of officers for 1913 resulted in the choosing of Dr. A. P. Williams of Neodesha for president; Dr. C. A. Thomas of Fredonia as vice-president; Dr. E. C. Duncan of Fredonia as secretary and treasurer; Drs. F. M. Wiley and A. C. Flack of Fredonia and Dr. C. I. Randall as board of censors. Dr. F. M. Wiley of Fredonia was elected to read a paper at our State meeting. in Topeka next May and was also chosen delegate to the State society.

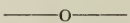
Dr. Shelton of Independence was present and made a short talk on Conditions Simulating Appendicitis, which was well received. (The talk, not the "conditions.")

Dr. W. H. Young read a paper on Psycho-Therapeutics. This paper was such a departure from anything our county society has ever discussed, that it brought forth much comment which was new, useful and interesting. I am sorry I cannot furnish you with a stenographic report of the discussion. The society voted that the secretary should ask that you print this paper in the State Journal and I am enclosing the paper.

Our county society is in good shape and all eligible physicians in the county belong with exception of about two. Those present at our Fredonia meeting were: Drs. Sharpe, Allen, Randall, Williams, Neodesha; Drs. Somers, Addington and Gray of Altoona; Dr. Riley of Benedict; Drs. Flack, Wiley, Young, Thomas, Duncan of Fredonia.

Adjourned to meet in Neodesha in March.

E. C. DUNCAN, Secretary.



Ninth and Tenth Districts, Dr. E. J. Beckner, Hoxie and Dr. C. S. Kenney, Norton, councillors:

Program of the Second Annual meeting of the Ninth and Tenth Councillors District, held at Norton, January 9th, 1913:

PROGRAM—10 A. M.

"Medical Societies in the Northwest", E. J. Beckner, Hoxie.

"Difficulties in Maintaining Medical Societies in Counties With but few Physicians," W. C. McIrvin, Atwood.

"The County Health Officer vs. The Profession", Frank H. Smith, Goodland.

"What the Smith County Society is Doing," F. A. Relihan, Smith Center.

"Surgery of the Bile Ducts," W. C. Lathrop, Salina.

"Serum Therapy, Case Reports," F. A. Carmichael, Goodland.

"Are We Doing all Possible for Our Tubercular Cases?" I. B. Parker, Hill City.

"Round Table."

Election of Officers Component Societies.

Rowland and Clifford's Production of "The Divorce Question." Guaranteed Attraction—Auditorium, 8 p. m.

—o—

NEWS NOTES

Surgeon General Reappointed.—It is announced from Washington that the president has decided to reappoint Brigadier-General George H. Torney as surgeon-general of the Army. General Torney does not reach the age for retirement until 1914.

—o—

Dr. Chas. S. Huffman, (our secretary) returned in December from a visit to Norfolk, Old Point Comfort and other eastern cities.

—o—

Dr. C. Clayton Koons and Mrs. Grace Roberts of Larned, Kansas were married November 27.

—o—

Dr. F. A. Harper who has been a victim of appendicitis has recovered from the operation nicely and is again at work.

—o—

Dr. A. A. Dickinson has returned to Pittsburg, after spending several weeks in post-graduate work at the New York Post-Graduate Medical School.

—o—

Dr. Hugh B. Caffey, councillor, visited the Bourbon County Medical Society at a regular meeting recently.

—o—

The Fort Scott doctors are up in arms over the action of the Knights and Ladies of Security in sending a special deputy there to work the town with a campaign for members and bringing an out-

side doctor to make the examinations. At a recent meeting of the Bourbon County Society a committee was appointed as follows: Drs. McDonald, Hopper, Vanvelzer, Aikman, Cavanaugh and Harrar to draft resolutions opposing the action of the Knights and Ladies of Security in sending a doctor from another city to make examinations during this special effort to secure members. One of this committee said to the writer "we think it is an outrage that the regular examiners residing in Fort Scott should be ignored entirely by the special deputy and that the head examiner should think it necessary to import a doctor to make these examinations and we hope that every member of the State Society making examinations for this order will resent this action on the part of the chief examiner."

—o—

Dr. Newman of Fort Scott has recently returned from a visit to Chicago and Rochester clinics.

—o—

Dr. O. B. Kiehl and wife spent Christmas holidays with relatives in southern Missouri. They returned to Pittsburg about January 1st.

—o—

The Labette county medical society held its regular meeting at the Matthewson Hotel in Parsons, November 27th. An attendance of nineteen men with free discussions made the meeting very interesting. Dr. A. R. Nash read a paper on Goitre. Dr. J. H. Henson discussed the removal of Tonsils. Dr. Boardman gave a report of some things observed at the recent clinical Congress in New York. Drs. C. A. Landes and H. C. Markham presented clinical cases.

The society voted the following resolutions: "Resolved, That the Labette County Medical Society requests its members to prevent the appearance of their names in the newspapers in connection with their cases.

—o—

OBITUARY.

David Surber, M. D. Eclectic Medical Institute, Cincinnati, 1865; a pioneer physician of Kansas and president of the State Board of Health from 1888 to 1890; died at his home in Bonner Springs, November 23, from senile debility, aged 84.

—o—

William M. Cooley, M. D., Hahnemann Medical College, Chicago, 1868; a pioneer practitioner and clergyman of Dickin-

son County Kan; died at his home in Herington, December 3, aged about 78.

—o—

Edgar D. York, (license, Kansas, years of practice, 1901); a practitioner of Rawlins County since 1881; representative in the legislature in 1887-1888 and 1891-1892; a veteran of the Civil War; first Mayor of Atwood, Kan; died in the State Hospital, Ingleside, Neb., November 5, aged 75.

—o—

Albert P. Harrison, M. D., College of Physicians and Surgeons, Kansas City, Kan., 1902; of Coldwater, Kan; a member of the Kansas Medical Society; died in the Wichita Hospital, November 21, from heart disease, aged 39.

—o—

RESOLUTIONS.

Resolutions adopted by the Butler County Medical Society at the regular meeting held in the commissioners room of the court house, in El Dorado at 2 o'clock, p. m. December 19th, 1912.

Whereas, The Chiro-practors, Magnetic Healers, Patent Medicine Vendors, and other classes of medical fakers have combined under the catchy name of "League of Medical Freedom", to secure the repeal or modification of the present law regulating the practice of medicine in this state, and

Whereas, We believe that such change would be detrimental to the welfare of the public, and

Whereas, The duties and responsibilities of the local health officers have been greatly increased by the enactments of the legislature in recent years, and

Whereas, We believe that better service can be secured to the public by taking this office entirely out of politics, and

Whereas, This society has given careful consideration to the appropriation asked for by the State Board of Health, giving attention to each item separately, and believing that the total amount asked is very reasonable for the efficient service rendered the public by the board, therefore be it

Resolved, By the Butler County Medical Society,

That we respectfully request our senator elect and representatives elect to oppose any change or modification of the present Medical Practice Act.

That we urge them to support the proposed bill for the appointment and compensation of County Health Officers,

That we request them to use their best efforts to secure the appropriation of the Full Amount of money asked for by the State Board of Health. Be it further

Resolved, That a copy of these resolutions be forwarded to Hon. J. D. Joseph, senator elect, and to W. J. Houston and J. M. Satterthwaite, representatives elect, by the secretary of the Butler County Medical Society, who is hereby authorized to append our names thereto.

The above resolutions were adopted unanimously.

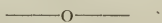
J. R. McCLUGGAGE,
Secretary Butler County Medical Society.

—o—

REVEIWS.

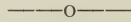
From a study of 3,000 autopsies, R. C. Cabot, Boston, (Journal A. M. A., December 28), wishes to call attention to three points, namely: 1. A goodly number of "classic" time-honored mistakes in diagnosis are familiar to all experienced physicians because they make them over and over. Some can be avoided, other are almost inevitable, but all should be borne in mind and marked by us with the danger sign. 2. Some common diseases are relatively inaccessible to diagnosis, no matter how careful. 3. There are still others, less familiar to the profession and all the more deserving to be watched for among the commoner mistakes. He enumerates: "acute gastritis," a rare disease in adults, as a rule, appendicitis or gall-stones being the correct diagnosis; "chronic indigestion" usually a mistake, the actual condition being ulcer, tuberculosis, constipation or colon cancer; "bronchitis" at autopsy or in the outcome usually proves to be phthisis, bronchiectasis or bronchopneumonia; "asthma" beginning after middle life usually means cardiac or renal disease; "unresolved pneumonia" is frequently interlobar empyema; "malaria" often means phthisis, liver syphilis and abscess of urinary infections; "typhoid fever" may mean tuberculosis or latent sepsis; "rheumatism" may mean a number of things, and is the most dangerous of all diagnoses to the honest physician; "cystitis" is usually a symptom and not a disease; "hemorrhoids" often mark rectal cancer; "neurasthenia" showing itself in youth on the basis of congenital tendencies and in middle age as a symptom of organic disease, such as paresis, arteriosclerosis, etc. The incipient stages of this disease are rarely recognized, and the same is true of gastric ulcer, pernicious anemia, leukemia, etc. The percentages of diagnostic success do not, in Cabot's opinion, depend to any considerable extent on the possession or

lack of special skill. There are diseases that kill so quickly that the period of observation is too brief. With our present limitations of diagnostic methods, few of the mistakes mentioned above could have been avoided with certainty. Among relatively unfamiliar mistakes, revealed, for example, by post-mortems. Cabot mentions spinal tuberculosis, acute uremia, of which he has never found a correct diagnosis, though it is often so made. He does not deny that it may occur and be recognized at post-mortems as the cause of death, but in his study of over 3,000 autopsies he has not met with it. He has, therefore, ceased to consider acute uremia in a diagnosis of case of sudden coma. Cirrhosis of the liver with its long period of latency is more frequent, he thinks, than its recognition would make it appear, and we should consider it as a possibility in all cases of sudden "causeless" coma, especially when unexplained hematemesis is a main symptom. Cancer of the colon is another disorder frequently unrecognized, as well as cancer of the esophagus and non-amebic hepatic abscess. He gives instances of failure to make correct diagnosis observed by him in these disorders. Lastly, he says, though the frequency of phthisis complicating diabetes is a frequent fact, it is not generally recognized, and he thinks there is a peculiar latency and lack of symptoms in this type of tuberculosis. In thirty-nine autopsies of diabetes there were nine cases of active tuberculosis, and not one of them was recognized in life. The clinical picture was quite different from that in non-diabetics.



Scarlet Fever.—The recent advances in our knowledge of scarlet fever since the summary by Hektoen (*Journal A. M. A.*, April 6, 1907, p. 1158), are reviewed by K. K. Koessler, Chicago, (*Journal A. M. A.*, October 26), with special reference to the question as to the primary or secondary role of the streptococcus in the disease. He finds from the facts published that it is plain the serum of scarlatinal patients contains for antiboides the streptococcus, which speaks undeniably for the intimate biologic relation of this germ to scarlet fever. The existence of a specific scarlatinal streptococcus, however, is not demonstrated and the primary etiology it still obscure. A similar condition prevails in small-pox, according to DeWael and Sugg, but this does not justify us in assuming that small-pox is a streptococcal disease. Since the secondary infection, however, often determines the ultimate fate of the patient, a specific treatment is suggested, and Koessler emphasizes that only those anti-streptococcic serums should be used which have a potency in content of anti-bodies or faculty

to stimulate their production, ascertained by reliable laboratory tests. He mentions especially the Gabritschewsky prophylactic treatment, and does not accept the view that the results of this vaccination prove the primary etiologic role of the streptococcus as held by Viadlmiroff. From his own experiments with the complement deviation method, which are mentioned, he thinks the following conclusions are suggested: 1. The serum of scarlet-fever patients contains specific antibodies for an unknown virus. 2. This unknown virus seems to be present, especially in the cervical lymph-nodes. In conclusion, he says that the advances made in the last five years as reviewed by him show that "though the etiologic agent has not been found and is yet to be discovered, the place to be attributed to the streptococcus has been more clearly recognized. The streptococcus almost constantly present leads to a systemic reaction of the organism which finds its expression in the presence of antibodies against it. The streptococcus, however, can no longer be identified with the virus of scarlet fever, whose existence and presence in the lymph-nodes in a high concentration must be assumed from the presence of specific antibodies in the blood. The experimental transmission of scarlet-fever to apes and monkeys substantiates this statement and points to new possibilities for the closer study of the nature of this virus."



Treatment of Gastric Ulcer.—Sir Bertrand Dowsan (British Medical Journal, August 3, 1912), in opening a discussion on the pathogenesis, diagnosis and medical treatment of gastric ulcer, said that he would consider gastric ulcer as "mucus ulcer" and "chronic ulcer." By mucus ulcer he denoted an ulceration of the mucous membrane. It was usually a subacute condition, tending to heal quickly and completely. Sometimes, however, it progressed rapidly into perforating ulcer, or took on the characteristic of a chronic lesion. By chronic ulcer he understood a condition involving most or all of the coats of the stomach, usually appreciable by sight and touch without opening the stomach. Duodenal ulcer was included because the duodenum above the common duct was embryologically, functionally and pathologically closely related to the stomach, and the problem on the two sides of the pylorus was the same. Mucus ulcers were the combined effects of lowered vitality or damage of the mucous membrane, and increased acidity of the gastric juice; the damage might be by local bacterial infection or toxins acting on the epithelial cells or on the lymphoid follicles, or by local hemorrhage or trauma.

The clinical resemblance between mucus ulcer and gastritis was very close, and there might be no distinguishing features between them. Chronic ulcer differed clinically from the older descriptions of this condition, and the patient was nowadays more often a man than a woman. As diagnostic features he emphasized pain, tenderness and acidity, X-ray examination showed that the motility of the stomach was sometimes enhanced.

The most important part of treatment was rest in bed, accompanied by a diet requiring little motility, and by treatment directed against the acidity—namely, by alkalies. He recommended operative interference if medical treatment failed after two months, if return to work led to recrudescence of the symptoms, if hyperacidity persisted, and if any evidence of stenosis intervened.

Professor Saundby thought that the diagnosis was often very difficult, and that all doubtful cases should be treated as though gastric ulceration existed. Rest in bed he considered of first importance; but the old starvation method was futile, and, as he had insisted for twenty years, feeding by the mouth could be started when the patient was first put into bed. Radiography was of limited value.

Professor Michell Clarke said that the most important advance in knowledge of gastric ulcer was the division into acute or mucus and chronic forms. He remarked on the importance of oral sepsis and the diagnosis from cancer.

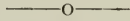
Dr. William Hunter regarded gastric ulcer as almost invariably due to staphylococcal and streptococcal infection from the mouth. Treatment should be especially directed to the source of infection. Dr. Charles Miller dealt with the histology of the disease. Prof. Vaughan Harley had found hyperchlorhydria in nearly all cases. He emphasized the importance of accurate chemical investigations. Volatile acids were increased only if pyloric spasm or obstruction existed, and pepsin was always present in large amounts. He believed drugs, especially bismuth subnitrate, were of great use. He considered gastroenterostomy should play no part in the treatment of uncomplicated cases.—*Therapeutic Gazette*.

—o—

MISCELLANEOUS

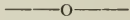
Not from Monkey, says Carrel.—“Many men have for years contended that the similarity in the construction of the monkey and man was proof sufficient as to the origin of the latter. Physiological science, however, does not deduct that way. This

standard regards the formation and similarity of the various tissues and glands, their natural length of life and their ability to thrive when transferred to the opposite being, as the fundamental basis for comparison. This being accepted as the true standard for reasoning, then most assuredly man never had an ape or an orang-outang as a prehistoric ancestor,"—Dr. Alexis Carrel, Pennsylvania Medical Journal.



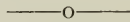
Capper Not Their Only Killing.—The Leavenworth Post says: "The doctors take the credit for killing Capper for governor. There are 2,500 doctors in an organization in Kansas and they all voted against Capper."

Killing Capper as governor is not the only killing Kansas doctors have accomplished. There are about that number of doctors in Kansas who have a wider reputation for what they kill than what they cure.

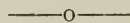


A Heathen Sect.—A little child of 5 years old died of diphtheria the other day, after one "present" treatment and several "absent" treatments by a "Christian Science" mummer. The deluded mother stated that the child had been "in error." By error she explained she meant a "slight sin." In other words, this strange sect teaches that the Judge of all the earth will slay a 5-year old child for a slight sin. Has heathendom ever evolved a more savage doctrine? It is akin to the horrible belief once taught that hell is paved with the skulls of unbaptized infants.

And these rivals of the Witch of Endor flourish exceedingly, fatten on the blood of their innocent victims and go unwhipped of the law because they call such a doctrine religion, and justice keeps her sword in her sheath and smiles benignantly, if not namely, on the lawless practices of this sect, because of the cloak of religion with which its votaries sanctimoniously cover their nakedness.—N. Y. State Journal of Medicine.



Mistakes.—There are bad mistakes, slight mistakes, mistakes of omission and those of commission, mistakes due to incomplete inaccurate, or erroneous observation, and mistakes due to hasty or illogical conclusion. There is a tendency to attach too much importance to some of the instrumental and other elaborate methods of diagnosis and to underestimate an all-round clinical experience and knowledge.—Leonard, Journal Missouri State Medical Association.



Newer Methods of Diagnosis vs. the Older.—I have often asked students at examination, "If a policeman were to bring a piece of garment with a stain on it, and he asked you whether it was blood, what would you do?" The answer in many cases has been, "Oh, I would use the spectroscope." I ask, "Have you a spectroscope?" Answer, "No, sir." "Then you would not use it." There is a tendency very often to run after the last new thing, and to run after the most out-of-the-way thing and to forget the common things.—G. V. Poore in *Clinical Journal*.

CLINICAL NOTES

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL SURGERY.

A five per cent solution of phenol in glycerine dropped warm into the ear will relieve the pain in non-suppurating acute otitis media.

Severe neuralgic pain over the bridge of the nose indicates pressure on the anterior ethmoidal nerve, probably due to a high deviation of the nasal septum.

To render a packing introduced for epistaxis easily removable insert a rubber finger cot into the nose, hold it open with clamps and pack the gauze into this.

Many a distressing frontal headache may be relieved by reducing the hypertrophy of a middle turbinate, preferably by streaking with a trichloroacetic acid.

When a large amount of pus can be aspirated from the ear the suppurative process has extended beyond the tympanum and mastoid operation is indicated.

Don't urge the radical operation for frontal sinusitis unless the symptoms are severe or conservative efforts have failed; the operation is disfiguring and the results are not always satisfactory.

Infections of the upper lip demand prompt and thorough treatment to avoid cerebral infections. Thrombosis of the nasolabial branch of the facial vein should be watched for. It appears as a reddened cord which can be felt in the groove between the cheek and nose. Serious complications may be averted by excision of the thrombosed vein.

When removing a dermoid cyst at the root of the nose don't forget that it may lead through the bone sutures to the meninges. Especially if the cyst or sinus is infected it is not wise to dissect it out too deeply unless persistent discharge after removal of the presenting portion cannot be cured by cauterization, etc.

The removal of a wedge of skin at the side of an ingrown nail, as in Cotting's operation, is rarely necessary and usually objectionable. Granulations disappear quickly when the nail segment is withdrawn; if they are exuberant they may be snipped or burned off.

A severe sore feeling in the throat is frequently complained of by nervous individuals. Close inspection will show numerous fine white spots surrounded by a red areola—herpes.

To Prevent Loosening of Teeth.—When it is desirable to counteract a tendency to this condition, the following mouth wash is recommended:

R̄ Acidi tannici,..... ʒii
 Tinct. iodi,..... ʒi
 Tinct. Myrrhea, gtts. lxxx
 Potassii iodidi,..... gr. xv
 Aquae rosae ad,..... ʒvi
 M. et Sig: Teaspoonful in a third of a tumbler of water every two hours as a mouth wash.—Practitioner.

Cancer Not Necessarily Painful.—The symptoms which more preeminently characterizes the early stages of cancer of the cervix is bleeding, bleeding between the periods, or some discharge containing blood in between the periods. At that time there is no pain whatever in cases of cervical cancer. Remember that, because the public mind associates pain with cancer, and the patient is apt to think because she has no pain that therefore, no matter what the trouble is, it is not likely to be cancer. But there is no more dangerous fallacy. For a long period, in fact, as long as the disease remains limited to the cervix itself, the patient has no pain at all. It is not until the disease begins to spread beyond the limits of the cervix that you begin to find the patient has pain. So do not be misled. Any unexplained bleeding, any bleeding, occurring between the periods—if we take a patient during menstrual life, or still more definitely, any bleeding occurring after a definite menopause has been established—is extremely suggestive of cancer.—Arthur H. N. Lewers in Clin. Jour.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, FEB. 1913.

No. 2

TONSILS AND ADENOIDS.

DR. H. L. SCALES, Hutchinson, Kansas.

Read before the Kansas Medical Society, May 12, 1912.

The title of my paper, to be strictly correct, should be "Tonsils and Adenoids in Children", as the consideration of tonsillar troubles in adults would make too voluminous a paper for this occasion. The question of adenoids and tonsils is one that is not only attracting the attention of the medical profession, but of the laity as well.

The general practitioner should be as interested in this subject as the specialist, as he usually sees these cases first. I am not expecting to advance any new ideas, as the average man is familiar with what is needed in these cases. There is one point on which I wish to lay special stress, and that is, that the tonsil should be removed in its entirety. We have all done tonsillectomies with the tonsillatome, but the time has passed for such work. With this instrument it is impossible except in rare instances, to remove that portion of the tonsil which lies in the supra-tonsillar fossa, and with this remaining the operation will be a failure, as in 90% of the cases this is the portion that gives trouble.

The hypertrophy commonly known as adenoids, or pharyngeal tonsil is made up of lymphoid tissue and is situated in the naso-pharynx. While this condition is essentially one of early childhood, yet it may continue beyond the age of puberty and has been found as late as thirty-five years.

In the greater number of cases the growth begins to atrophy after the age of ten and an adenoid that may have completely obstructed nasal breathing at ten, may leave the naso-pharynx nearly free at 20. This is not all due to a decrease in the size of the adenoid, but is also partly due to an increase in the naso-pharynx.

Children who suffer with adenoids are very subject to colds, ear-aches, bronchial affections, etc. Adenoids not only affect by the obstruction to respiration, but they furnish a fertile field for the growth of pathogenic bacteria.

A great many of the severe throat troubles commonly ascribed to inflammatory conditions of the faucial tonsils, are due to an inflammation of adenoid tissue.

An acute adenoid inflammation is not so soon recovered from and the cervical adenitis is much greater than in tonsilitis. Scarlet fever and diphtheria are very prone to attack adenoid tissue and it is not infrequently the first point attacked in diphtheria.

Children with adenoids are as a rule mentally dull as compared with children of the same age and consequently their school work suffers. They are not mentally backward, but they do not develop physically as they should. Such children are very sensitive to cold or dampness; and owing to the interference with respiration, due to the enforced mouth breathing, develop bronchial troubles very readily. The swelling in the adenoid closes the post-nasal space and this leads to many complications. Probably seventy-five per cent of the ear troubles of children are due to adenoids. The naso-pharynx is filled with ropy mucous that is very difficult to dislodge, and in blowing the nose, owing to the closure of the naso-pharynx, this is forced into the eustachian tube, and if infected, an acute otitis media occurs.

In the cases that are chronically enlarged, the obstruction to the eustachian tube prevents proper secretion of the middle ear and retracted ear drums, and catarrhal deafness ensues.

The diagnosis in most cases is easily made, but is sometimes rather difficult. There is a typical adenoid face that is found in most children affected with adenoids. Owing to the continual mouth breathing, the lines about the mouth and nose are obliterated, giving them a stupid appearance. The base of the nose is broadened and the mouth is always open. Such children sleep badly, snore and have night terrors.

The growth can, in some cases, be seen on direct inspection of the pharynx, but this is not to be depended upon. If the child is tractable and the throat is not sensitive, the adenoid can be seen with a mirror in the naso-pharynx, but, owing to the age of the patients, this is seldom successful, and the only way to make a positive diagnosis, is by direct palpation.

The finger should be carefully cleansed and passed gently back into the naso-pharynx, when it can be swept over the vault and the adenoid felt, if there. The sensation given to the finger

by an adenoid, if large, is of a soft semi-elastic mass, completely filling the naso-pharynx. A small adenoid can only be felt by sweeping the finger over the vault. Adenoid tissue bleeds very easily and in probably one-half the cases, the examining finger will bring away a little blood. In this, as in everything else, education of the sense of touch is necessary. It is possible to find adenoid tissue where none exists, and a small adenoid may be easily overlooked. The mistake most easily made is to fail to get behind the soft palate and to mistake that tissue for an adenoid. There is only one treatment for an adenoid, and that is removal.

Extensive experiments have been made to determine the results of treatment on the size of adenoids, and in every case the treatment has been of no benefit.

There have been many ways of removal; from finger nails to curettes. The most successful, and in fact one might almost say, the only instrument is the curette. I like the old Gottstein best. I have lately tried one which is becoming popular, designed by Barnhill, but cannot say that I like it.

In most cases an adenoid can be removed without the aid of an anaesthetic, and if this is possible, it is much better, as one can then have the patient in an upright position. The safest anaesthetic to use is ether. These cases do very badly indeed under chloroform. Results are so good and the danger so slight, that a child with adenoids should never be allowed to go without an operation.

The disease effecting the tonsils are very intimately connected with those affecting adenoids. Many children have adenoids who do not have pathological tonsils, but I think a child with diseased tonsils always has an adenoid. As with the adenoid, there is really only one treatment for tonsils that are giving trouble—and that is removal. And when I say removal, I mean removal of the entire tonsil. I am not now doing anything but an enucleation in the capsule. Until we find that the tonsil has some function, this is unquestionably the operation to do. I am inclined to think that some day we may be leaving a part of the lower lobe of the tonsil to perform its function, but just now it has no known function, so we take it out. I think a part of the lower lobe could be left without interfering with the successful results, as the tonsillar troubles come from the upper lobe.

A tonsillectomy in children is in all cases a hospital operation and should not be attempted unless one is absolutely sure of his technique. The patient should be on his side with the arm

pulled under, and behind—in fact, almost lying on his stomach. The upper shoulder is held so he will be supported and not roll too much on the stomach. The anesthetic is given in the usual way until the operation is ready to begin, when it is given through nasal tubes. In this way one is able to keep the patient thoroughly anaesthetized without in any way interfering with the operator. I first lay the patient on the left side and remove the right tonsil, then turn the patient over and remove the left. In this way one is always working on the upper tonsil and is not troubled with the blood. The head is on the side of the table with the face just a little lowered. In this way the blood goes out of the mouth and gives very little trouble. It is sponged out from time to time as necessary. The tonsil is grasped with a locking forcep and is pulled well inward and forward. Then with an ordinary scalpel with a long handle, an incision separating the anterior pillar is made, and is carried upward and around until the tonsil is completely separated from the pillars. The tonsil is then dissected loose until it is free from all attachments, when a snare is thrown around it and the final separation made.

If the dissection has been carefully made, one will have the tonsil complete in its capsule. Should there be any tonsil left, this can be removed with a tonsil punch. If, on examination, one is not sure the tonsil has been removed in its capsule, the examining finger can easily detect any remaining tissue by the feel. This operation is very simple and very free from danger. I have never had a hemorrhage and do not think I will, unless I am so unfortunate as to cut one of the pillars or the superior constrictor muscle.

After the tonsil is removed, a gauze sponge is held in the cavity until all hemorrhage has ceased. As to the after treatment, I have none. I do not use a gargle, sprays, or anything of that nature. If they complain of pain, I have heat applied or have them hold some very hot water in the mouth. But they very seldom require anything. Usually in twenty-four hours, the patient is up and around.

In conclusion, I wish to say, do a tonsillectomy, not a tonsillotomy.

—o—

ARTIFICIAL INFANT FEEDING.

J. T. SCOTT, M. D., St. John, Kansas.

Read before the Kansas Medical Society, May 1, 1912.

In the absence of statistics I venture the assertion that the

great majority of infants, in this country at least, are breast fed, a condition that is fortunate for the mother and doubly fortunate for the child. The entire profession recognizes the fact that derangements of digestion and nutrition constitute practically the sum total of the disorders of infancy. The breast fed infant receives that food which nature furnishes for it and which is most accurately adapted to its physical growth and digestive capabilities. Under such circumstances the likelihood of infantile diseases is reduced to a minimum. Unfortunately, on the other hand, there is a large number of infants born into the world that have not the advantages of maternal nursing and must be nourished by artificial feeding. It then becomes an important question as to the selection of a food that will most successfully replace the mother's milk. There is no perfect substitute for breast milk. Unquestionably the nearest approach to it is cow's milk.

In considering then the question of artificial feeding, we shall have to deal mainly with cow's milk. I have stated that cow's milk is not a perfect substitute for mother's milk, but requires certain modification to render it digestible when introduced into the infantile stomach. It is obvious then that a knowledge of the constituents of cow's milk is essential to its rational modification.

We know that breast milk, after nursing is well established, is composed of 4% fat, 6% sugar, 1.5% proteids, .20% salts and 88.30% water. Average cow's milk has the following formula: fat 4%, sugar 4.5%, proteids 3.5% to 4%, salts .70% and water 87.30%.

In comparing cow's milk with mother's milk, it is to be observed that the percentage of fat is the same, the percentage of sugar is somewhat higher in breast milk, the percentage of proteids in cow's milk almost three times that of breast milk, and the percentage of salts in cow's milk three and a half times that of breast milk.

We find then that the constituents of breast milk and cow's milk are the same but that the percentages differ.

Clinical experience together with chemical and microscopical observation, have demonstrated other differences. While the reaction of breast milk is universally alkaline, that of cow's milk is amphoteric or positively acid. The fat droplets in mother's milk are finer and have less fatty acids than cow's milk, are more completely emulsified and hence more readily absorbed. The proteids of breast milk form small, soft homogeneous curds when introduced into the stomach, while the cow's milk proteids form

large, firm, tough curds. The proteids and fat of cow's milk then are not identical with the proteids and fat of mother's milk, hence it is obvious that cow's milk so modified as to correspond exactly with mother's milk, will not necessarily prove to be the formula of election. A modification such as the above mentioned would seem to be along strictly scientific lines and for that reason mainly, the establishment of milk laboratories in this country where prescriptions calling for definite percentages of pure milk could be filled, was heralded as the coming solution of the artificial feeding problem.

There is no question that an immense stride was taken, in emphasizing the necessity of pure milk and proper modification, but as a practical solution of the difficult subject of infant feeding, it must be admitted that it fell far short of the anticipations of its enthusiastic adherents.

After considerable investigation I do not hesitate to say that there is no field in medical literature where there is a greater diversity of opinion in the profession than that of artificial infant feeding; and this statement applies not alone to the general practitioners but to the leading pediatricists as well.

In European countries, more especially England, France, Germany and Austria, the prevailing custom is the use of whole milk undiluted or diluted from one third to one-half with water or farinaceous water. They argue that high dilutions of milk are necessarily weak in nutritive value, that the excess of water dilutes the gastric juices to such a degree as to render them incapable of normal action and at the same time frequently causing gastric dilatation. They recommend longer intervals between feedings so that the large curds may be more thoroughly digested.

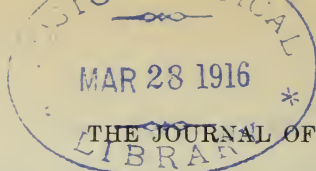
In America the prevailing custom may be designated as the direct opposite in some respects to that of Europe. That is to say, high dilutions and more frequent feeding is the rule of preference here and whole milk undiluted is rarely ever recommended during the first year of infantile life. The weakening of gastric juices and damage to the gastric glands together with gastric dilatation due to so called high dilutions are not considered demonstrable; while upon the other hand the use of a food of high proteid content, with its large, tough, indigestible curd, is capable of producing irreparable damage, both functional and organic.

However, there is another question of the greatest importance,

that calls for first attention in all cases and under all circumstances. I refer to the purity of the food. Pure milk unmodified is infinitely superior to impure milk after the most scientific modification. It is the difference between good food and bad food, between nutrition and poison, between clean curds and infected curds, between prevention and disease. The establishment in some of our large cities of depots where certified milk—that is—clean, pure milk can be obtained, is of more importance to the general public than milk laboratories where percentage prescriptions are filled. I do not wish to appear opposed to the laboratory principle, I am in hearty accord with it, but it is necessarily expensive and can never be the food of the great mass of humanity, while certified milk at a price that the average class can afford, with intelligent modification, can successfully take its place.

A very large percent of the infants in cities and all of the infants in small towns and rural communities that require artificial feeding will of necessity receive milk that is modified at home. The method in common use for home modification consists of simple dilution with three or four parts of diluent, usually water; to one of whole milk, and the addition of milk sugar. If four parts of diluent are used we have a food consisting approximately of, fat .80%, proteids .70%, sugar .90% and salts .15%. The addition of 4% sugar, thereby increasing the sugar percentage to 4.90% gives a fairly representative food for use during the first two weeks of infantile life, although the proteids and fat are double what they should be during the first five days, especially for premature and weak babies. The addition of lime water in the proportion of one to twenty, or of bicarbonate of soda one grain to the ounce, insures alkalinity of the food, promotes its digestibility, and should be invariably used.

It should be remembered that the proteids are the most difficult to digest and next to them, fat. The sugar and salts so rarely occasion difficulty as to render them negligible. The object then in milk modification is the reduction of the percentage of proteids and fat and the increase of the percentage of sugar. During the first week of infantile life the proteid percentage should not exceed .50% and the fat percentage should not exceed 1.50%. The following table from Judson and Giddings gives the fat, proteid and sugar percentages adapted to the average infant's digestive powers, for each month during the first year:



Age	Gastric Capacity	Proteins	Sugar
Premature.....	1.00	0.25	4.00
1st to 4th day.....	1.00	0.30	5.00
5th to 7th day.....	1.50	0.50	5.00
2nd week.....	2.00	0.60	6.00
3rd week.....	2.50	0.80	6.00
2nd month.....	3.00	1.00	6.00
3rd month.....	3.00	1.25	6.00
4th month.....	3.50	1.50	7.00
5th month.....	3.50	1.75	7.00
6th to 10th month.....	4.00	2.00	7.00
11th month.....	4.00	2.50	5.00
12th month.....	4.00	3.00	5.00
13th month.....	4.00	3.50	4.50

It may be stated as a general rule that from the beginning of the second month to the end of the first year a fat percentage below two and a proteid percentage below one is subnormal, a fat percentage above four and a proteid percentage above three is abnormal. If it is desirable to raise the percentage of fat without increasing the proteids it can be accomplished by a mixture of whole milk and top milk with the necessary dilution. In any dilution it is always necessary to add sufficient sugar to bring the percentage up to at least six. It is not to be expected that every case will thrive even after most painstaking care and accurate modification. Some infants seem utterly incapable, for a time at least, of digesting any modification of cow's milk. Under such circumstances it will usually be wise to use whey or peptonized milk for a short time, always returning gradually and as soon as expedient, to a milk diet. Where an increase in the proteids is desired, it can be accomplished by the use of sufficient whey as the diluent.

When we are assured that the milk is pure and that absolute cleanliness is observed in its handling, and preparation, there is no occasion for any treatment of the food save such simple modification as the individual case demands, while on the other hand, if there is a likelihood of contamination, or if the weather is extremely hot, causing rapid change, it is safest to pasteurize, sterilize or boil the milk, that is to say, cook the food.

In pasteurization the milk should be placed in a stoppered bottle and heated in a water bath for twenty to thirty minutes at 155° F. This kills the germs of tuberculosis, diphtheria, typhoid fever, etc., without producing chemical change in the milk. It should be kept at a temperature of 45° F. until used.

To sterilize the heat must be raised to 212° F. and maintained for at least one and one-half hours. This produces chemical changes that may be inimical to digestion and assimilation.

Condensed milk is quite extensively used as an infantile food and it is but fair to say in many cases,, with apparent success. It has it's uses, such for instance, as times and circumstances when good milk can not be obtained, or journeys are to be taken with milk unavailable, or periods of digestive trouble when whole milk must be withdrawn temporarily. But as a reliable food for continuous use it is not to be compared with good cow's milk. Infants fed continuously with condensed milk may look plump and healthy, but sooner or later they develop evidences of rickets, anemia, marasmus, etc.

Proprietary foods all contain starch. Milk has no starch and the starch transforming ferment ptyalin is not produced by the digestive apparatus until the infant reaches the fifth or sixth month of life, hence the apparent conclusion is that starch should not be made a food constituent during the first five or six months. After that time the gradual increase of starchy food is not only permissible, but desirable.

Next, if not of equal importance, to that of proper modification is the regulation of the amount of food and the intervals between feedings. For the sake of brevity I present the following table and the suggestion that it represents only an average which may be modified to suit individual cases:

Age	Gastric Capacity	No. Feedings	Intervals	Total Am't
1st month.....	1 oz.	10	2 hr.	10 oz.
2nd month.....	2.5 oz.	8	2.5 hr.	20 oz.
3rd month.....	3 oz.	8	2.5 hr.	24 oz.
4th month.....	4 oz.	7	3 hr.	28 oz.
5th month.....	5 oz.	7	3 hr.	35 oz.
6th month.....	6 oz.	6	3 hr.	36 oz.
7th month.....	6 oz.	6	3 hr.	36 oz.
8th month.....	7 oz.	6	3 hr.	42 oz.
9th month.....	7 oz.	6	3 hr.	42 oz.
10th month.....	9 oz.	5	3 hr.	45 oz.
11th month.....	9 oz.	5	3 hr.	45 oz.
12th month.....	9 oz.	5	3 hr.	45 oz.

A good rule to remember the approximate amount at each feeding is as follows: At birth, 1 oz., at 6 months 6 oz., at 12 months, 12 oz. That is during the first six months the infant has his food increased by one ounce a month; during the second half of the first year he should get an increase of one-half ounce each month.

Practical Medicine series, 1906, vol. 7, calls attention to the modification of milk by sodium citrate and quotes from Pediatrics as follows:

J. W. Vanderslice reports excellent results from the addition of citrate of sodium to milk, and after a years experience, declares it the most satisfactory and successful method of artificial infant feeding he has ever used in his clinic. He found every child would take and could digest milk modified in this way. All of the patients under observation showed a more rapid rate of growth than usual and a perfectly normal development. Among the younger children signs of acute rachitis disappeared soon after this diet was ordered. The citrate of sodium renders the curd of cow's milk finer and more easily digested. It is cheap, convenient and easily administered. It makes possible the giving of more highly concentrated milk and lessens the danger of underfeeding. On account of the ready solubility of citrate of sodium, as many grains to the dram of water are prescribed, as ounces of milk are taken, and a mixture containing enough for one weeks feeding is given the mother. For example, an infant taking milk 4 ounces, water 2 ounces, sodium citrate 4 grains, six feedings each twenty-four hours is given a prescription for sodium citrate drams 3, chloroform water m 10, aq. dest. ounces 6. The chloroform water is added to prevent a fungoid growth.

The Medical World, April, 1912, in an editorial entitled, "The Proper Food for the Bottle-Fed Baby," says: "There is one drug which has been of more service to the editor than any other single matter. We have used it sometimes when we could give no valid reason why it seemed to be indicated, and nearly always with the happiest results, even when the previous modification seemed to be practically perfect. Now, we use it as a routine measure in all cases of home modification of milk. We refer to citrate of soda. We give 15 to 60 grains a day, in divided doses, dissolved in the milk in the bottle. It aids in regulating the peristaltic action of the bowels; it makes the curd of the cow's milk more flocculent and easier of digestion; it causes vomiting to disappear in all cases where the modification and quantity are anything near like correct. We suggest that the physician never forget to add sodium citrate after he has completed his modification."

A very common fault to which attention should be called is the failure to administer sufficient water to the growing infant. It should be given preferably a half hour before feeding and in liberal quantities.

When the milk is regurgitated immediately after feeding, before there is curd formation, it is usually due to too rapid feeding or to overdistention of the stomach. It can usually be rem-

edied by procuring unpierced nipples through which smaller holes may be made or by resort to the Bonwill method which consists in inverting a small nipple in the neck of the bottle and placing a second over it, thus retarding the flow of milk. If the baby cries from one feeding to the next it may be due to underfeeding, to improperly proportioned food, or to colic. The proteids and fats are the troublesome constituents and should be modified to suit the individual conditions.

During the hot season babies that are receiving food of fairly high proteid and fat percentages should be carefully observed and upon the first appearance of digestive derangement should have the fats and proteids decidedly reduced.

The character of the stool conveys valuable information as to the completeness of digestion and the condition of the gastrointestinal tract. If the stool is green at the time of passage, it is due to fermentation, the result of bacterial action. It should be remembered that all stools turn green shortly after evacuation, due to subsequent oxidation. Curdy lumps in the stool are due to casein or fat. If due to casein the lumps are tough and yellow. if due to fat they are soft and smooth like butter. Where there is much slime it is due to catarrhal inflammation. If the mucus is mixed with the fecal matter the trouble is high in the bowels, but when flakes or masses of mucus are passed it is near the outlet. Yellow, watery stools are commonest in hot weather and are due to depressed nervous conditions. Very foul stools are due to decomposition of the albuminoid principles. Profuse, colorless, watery stools, with very little odor are usually due to some infective principle of the character of that of Asiatic Cholera and the condition is commonly known as cholera infantum.

Time and patience are necessary in giving instructions to the nurse or mother as to the proper modification and administration of food, but it is the only safe course to pursue and the results will in every instance justify the means.

To save time for the doctor and insure accurate detail in preparation and administration of the food, a printed list of instructions, such as can be left with the mother, will be found a reliable convenience. I present such a list, with the suggestion that it may be modified to suit individual conditions.

Instructions for preparing and administering food:

1. Upon receipt of bottle place on ice until day's feed is prepared.
2. Cleanse all utensils with boiling water just before using.
3. The following articles are necessary: (1) A jar of boiled

water, or freshly prepared barley water. (2) Jar for milk sugar. (3) Bowl of freshly boiled water in which place tablespoon, knife, and a one ounce dipper. (4) Eight ounce glass graduate. (5) Two freshly scalded preserving jars and caps. (6) Bottle lime water. (7) Enameled or glass funnel, freshly scalded.

4. Thoroughly wash hands, place articles to be used on clean napkin, scald neck and cap of bottle, remove paste board cap with knife, remove upper half inch of milk with spoon and discard if cap has been carelessly adjusted.

5. Remove.....ounces of top milk with dipper, pouring off enough to allow space for insertion of dipper, or measure..... ounces of cream and..... ounces of whole milk (or skimmed milk) in glass graduate. The top milk (or milk and cream,) as measured, should be poured into one of the freshly scalded quart jars.

6. Dissolve.....ounces milk sugar in.....ounces of boiling water (in the graduate,) pour into the other quart jar and addounces of boiled water (or barley water.) Add.....ounces lime water. Pour contents of one jar into the other and mix thoroughly. Cap tightly and place on ice until ready for use.

7. On feeding shake jar, pour proper quantity into freshly scalded feeding bottle. Scald nipple before adjusting, stand bottle in hot water until warm to back of hand.

8. Cleanse bottle with cold water after feeding and keep filled with water until ready to scald for use. Bottles should have rounded corners to facilitate cleansing.

9. Cleanse both surface of nipple with soap and cold water and keep in borax solution until ready to scald for use.

10. **Feeding.**—First month every.....hours from.....a. m. to.....p. m., with.....night feedings.ounces at each feeding.

Second and third months.....ounces every.....hours froma. m. to.....p. m., with.....night feedings.ounces at each feeding.

Fourth and fifth months.....ounces every.....hours froma. m. to.....p. m., with.....night feedings.ounces at each feeding.

Sixth to eighth months.....ounces every.....hours froma. m. to.....p. m.,ounces at each feeding. No night feedings.

Ninth to twelfth month.....ounces every.....hours froma. m. to.....p. m.,ounces at each feeding.

SYPHILIS.

DR. M. K. LINDSEY, Topeka, Kansas.

Read before the Golden Belt Medical Society, January 2, 1913.

In this review I desire to present a brief criticism of some of the most recent methods of diagnosis of syphilis and outline what I consider the present idea of its treatment. Till recent years syphilis had been studied almost exclusively clinically, but in 1905 a new impetus to research was provided by Shaudinn, through his discovery of the spirochete and in 1907 by von Wassermann, who adapted the work of Bordet and Gengou on complement fixation and a practical method of the sero-diagnosis of syphilis.

Since then many of our ideas regarding syphilis have had to be completely remodeled. The great mass of literature purporting to bear on these subjects leads the average medical man only to despair when dealing with any phase of the disease because few of us are in a position to make any important deductions of our own from either a clinician's or pathologist's point of view, and the articles published are in so many cases indefinite or misleading. It is my object then, to review some of the methods now adopted, some of which I have had the opportunity to study in the venereal wards of the New York City Hospital.

In those cases which are obscure from the clinical aspect, the diagnosis largely has to be made by the laboratory and the relative value of these findings has been the object of considerable discussion. The discovery of the organism either in stained specimens or by dark fluid illumination would seem to solve the problem of certain patients, and probably in the hands of trained observers familiar with the morphology and other characteristics of the spirochete, this method could be relied upon. It must be remembered however, that other organisms such as the spirochete refringens and spirochete buccalis, etc., may readily be mistaken in spite of the ease of differentiation in which some writers would lead us to believe. Thus, all cases showing spirochetes by no means all represent cases of syphilis.

A method which has been referred to rather prophetically is Noguchi's Luetin reaction. This was devised after the cultivation of the spirochaete was accomplished, and acts in luetic subjects in a manner similar to the von Pirquet reaction in tuberculosis. The spirochete emulsion which is injected, causes a local skin reaction in cases that exhibit syphilitic antibodies. I con-

ducted a series of these tests for some time in the city hospital, New York, under the direct supervision of Noguchi, with the following results: Practically all primary and secondary cases gave negative results; late secondaries especially those under treatment and tertiary cases were positive for the most part, although some negative at first became positive under treatment. It is only therefore, of use in some tertiary and latent cases, and represents a test of the immunity rather than any index of spirochaete activity. To determine any active growth of the syphilitic toxin in the system, the Wassermann reaction is the most accurate gauge we have at present, and is generally accepted by the profession as a most important diagnostic measure, when the disease has become general, usually from five to eight weeks after the appearance of the initial sore. I am not going to discuss the merits of the different methods employed in doing this reaction, as the results are satisfactory in any case where standardized materials are used by those qualified to do the work. Here, again, as in the identification of the organism, the value of the test is largely determined by the ability of the serologist. Although one cannot put too much emphasis on this point, yet a large amount of the dissatisfaction by clinicians with the test is the result of failure of their interpreting certain facts with which many physicians are not thoroughly familiar.

We have noted that the test is useless before the disease becomes general, and is also of no significance when the patient is taking mercury or salvarsan, unless positive. The generally accepted figures in regard to its occurrence otherwise, are as follows:

Secondary.....	95%
Tertiary.....	75%
Latent Syphilis.....	50%

These figures are subject of course to considerable variation, subject to the changes of technique, which are constantly being made. It is also interesting to note the occurrence in the so-called parasyphilitic conditions. General paresis 87%, using spinal fluid. Tabes, 60% with spinal fluid, syphilis of the central nervous system, only 20%, using spinal fluid, but much more frequent with blood serum. This discrepancy is avoided by using approximately five times the amount of spinal fluid, which makes the two reactions of practically the same occurrence.

An important procedure in determining a case or in diagnosing latent or otherwise negative cases, is the "Reaction Provacative" of Ehrlich. This consists in administering about half the usual dose of salvarsan or the later preparation and then repeating the

Wassermann, which will be found positive in practically all uncured cases in from one to ten days at most. Whatever the Wassermann reaction may be capable of doing, it at least permits us to diagnose syphilis as a rule, sometimes before the secondary eruption appears, and brings under curative treatment a great many latent and so-called parasyphilitic conditions.

The diagnosis having been made, it then becomes the duty of the physician to institute a form of treatment aimed at a complete eradication of the infection, and not simply at relief of symptoms.

Before taking up specific treatment, I would like to call attention to the preparation of patients, which will prevent in many cases, distressing complications. The early cases, where diagnosis is delayed, offer opportunity for giving careful attention to the general condition, where digestive disturbances and faulty hygienic conditions can be corrected. An important measure is the care of the mouth and teeth. These should be examined with special reference to pyorrhoea, and putrefactive conditions. The omission of tobacco is advisable in lessening mouth and throat irritation.

The age and sex and general condition of the patient having been considered, we now proceed to treatment, which of course must be modified according to the stage of the disease. The combined treatment of mercury and salvarsan has had almost universal approval, and now, with the newer preparation, neo-salvarsan, (Ehrlich's preparation No. 914), which on account of the absence of some of the objectionable features of "606" gives us a safer and more satisfactory result. The methods of administering mercury are many, and some of them are resorted to with advantage, under certain circumstances. I need not touch on the older methods of treatment, especially, by mercury pills, as experience has shown, they rarely effect a cure. I will only speak of one which I believe will be found useful under ordinary conditions. The suspension of the salicylate of mercury in albolene in the proportion of one grain to ten minims, and injected intramuscularly, preferably in the gluteal region, is a method perhaps as free from disadvantage as any. It is best prepared in small amounts and must be thoroughly shaken before the syringe is filled. I gave on an average of forty injections of this each week, for a period of several months, and did not have a single abscess or untoward complication during that time. Care is exercised to avoid vessels and nerves, and the dissemination of the drug is facilitated by having the patient gently massage the part for a

few minutes after. Our routine method one year ago in primary and secondary cases was to follow two injections, one week apart, of salvarsan with injections of one grain of the salicylate of mercury weekly, and after twelve treatments, a final dose of salvarsan was given, which terminated the course. After this the Wassermann reaction was repeated each month, for three months, and if at any time it again became positive, the course was repeated. At the end of six months from the completion of treatment, with a negative reaction, the patient was regarded as cured.

Salvarsan was at first administered intramuscularly (two years ago), but this was abandoned on account of the local reaction. After we became better acquainted with the action of this drug and had learned to give smaller doses, (3 grams), made up with freshly distilled water, we had generally gratifying results. I made a daily microscopic examination of the urine in all cases, and the majority showed red cells in varying amounts, and some of them hyaline and granular casts from five to seven days following injection. This led us to believe that severe kidney lesions were a contra-indication, although small amounts of albumen only caused us to diminish the dose. Ehrlich says that myocardial degeneration contra-indicates its use and it is stated by Fordyce and others, that syphilis of the central nervous system should be treated with very small doses on account of the convulsions and transitory paralysis which frequently follows. These are ascribed to intensification of certain focal inflammatory central nervous lesions. All syphilitic conditions showing cord changes are advantageously treated by withdrawing thirty to forty cubic centimeters of blood, 1 to 2 hours following injections of salvarsan, and injecting the serum which separates from this, into the spinal canal after first withdrawing a similar amount of spinal fluid. One case of gastric crises treated recently, in this way, responded readily with complete relief of gastric symptoms. This treatment is not used to advantage in brain lesions, as it has been demonstrated that there is very slight transmission of any medication from the spinal canal, through the foramen of Monroe. Neo-salvarsan was produced by the addition of a sulphoxyl radical, making a freely soluble compound in water. It is a more granular powder than the older preparation and deteriorates more readily. This is shown by a change in color from orange yellow, to yellow ochre. It is put out in tubes containing approximately .9 gm, which is equivalent to .6 gm. of salvarsan, and is prepared for use by the simple addition of one hundred and fifty c. c., of freshly distilled filtered water. Special emphasis should be placed

on this last point, as water which has stood for even a short time, is often responsible on account of its alkaline degeneration for rather serious reaction on the part of the patient. At the present time, I am using neo-salvarsan prepared in water, at room temperature, and administered intravenously in beginning treatment in all cases. The first dose usually consists in from .4 to .6 gm. depending on the size of the individual, and increased to 0.9 at the fourth injection. So far, I have had no reaction with the exception of a slight rise of temperature. In all cases except tertiary lesions with secondary infection, I have obtained rapid disappearance of symptoms. These however, usually respond nicely, to mixed treatment with K I. Experimentally, in animals neo-salvarsan is shown to have a somewhat diminished toxic action and also has the advantage of being free from the caustic alkaline. Comparing the results of work done with trypanosones placed in solution ranging from one to a thousand up, we have the following: With neo-salvarsan, all motility was stopped immediately in dilutions up to one to ten thousand; all motility stopped in half an hour, in dilutions up to one, to one hundred thousand; with salvarsan motility ceased in ten minutes in one to one thousand solution; was stopped in half an hour in solution of one to twenty-five thousand. The last few years have therefore taught us that a large group of diseases, so-called parasymphilitic, such as tabes and general paresis, are active syphilitic lesions, and that effective treatment may both stop and prevent their progressive course. This also applies to many cases of severe anaemic aneurysms and heart disease. We are also able now, to diagnose and treat syphilis in its latent stage, and in its very earliest stages, before waiting, as we used to do, for the appearance of the characteristic eruption. By salvarsan and hypodermic injections of mercury, we are also able to get the patient under the influence of treatment, rapidly, and greatest of all, we are now in position, to know when treatment has been completely effected.

—o—

TREATMENT OF LOBAR PNEUMONIA.

DR. X. OLSEN, Clay Center, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

The subject of the first lecture I heard at medical school was "lobar pneumonia." I was very much impressed with the treatment the professor advocated. It consisted of beef essence, quinine, and whiskey. This was at a time when veratrum and

aconite had just had a popular run, and the profession was awakening to the fact that these were not suitable remedies with which to combat pneumonia. Not once, but many times, during his lecture, did this enthusiastic medical teacher admonish his students to treat their pneumonia patients with beef essence, quinine and whiskey. Four years later I heard the same teacher, in the same lecture room, recommend large doses of sodium salicylate in the treatment of this disease.

At one time, a few years later, I heard a teacher of medicine recommend large doses of potassium iodide, as a good remedy to use in the early treatment of pneumonia. Others have recommended what they called the antiseptic treatment, such as creosote or guaiacol.

Thus the pendulum has swung from one extreme to the other. The list of remedies used is long and varied as can readily be seen by glancing over some of our text books. This only proves that nothing very satisfactory has yet been found. In fact the old professor's beef essence, quinine and whiskey is still our best treatment if we interpret it to mean good nourishment and supportive and stimulative medical treatment, intelligently used.

Pneumonia is an acute, self-limited infection. We have no remedies at our command that have any effect, whatever, on the pneumonic processes. The successful treatment of pneumonia, therefore, consists of leaving the pneumonia severely alone, and treating the patient as occasion may demand or complications arise. Never use routine treatment.

A patient sick with pneumonia should immediately be put to bed in a room where plenty of fresh air and sunlight is available. The temperature of the room should be kept uniform, at about sixty-five degrees. The bed clothing should be warm and light, and the patient should wear a cotton jacket or a chamois skin vest. No other local applications are necessary. Poultices of every description are mentioned here, only to be condemned. Not only do they do injury by causing the patient to lift a heavy weight with each inspiration, but their constant changing necessitates exposure of the chest, thus alternately heating and chilling the surface. When a poultice is removed the skin underneath is moist the pores are open and to expose it to the room temperature, is doing on a small scale, that which if done on a large scale would manufacture ice; namely, causing refrigeration by evaporation. Certainly such treatment can do no good to say the least. It is difficult to understand why men, otherwise splendid practitioners of medicine, insist on sticking to this traditional fallacy.

One condition which I have learned to dread, and which I have not seen emphasized in any text book, is a distended abdomen. This is usually due to a faulty elimination and improper feeding. In this condition the diaphragm is pushed upward and greatly interferes with the patients breathing, which is already crippled. I have seen very few fatal cases where this distressing symptom was not present.

In every case of pneumonia it is the duty of the physician to carefully and frequently investigate the functional activity of the gastro-intestinal canal. In the beginning of an attack of pneumonia it is generally wise to give a course of calomel to be followed with a saline. Later on an enema is often the best thing to use. Late in some cases, there seems to be a condition that almost amounts to a paresis of the bowels. The tympanites becomes very great and cathartics seem to have no effect. Here an enema of two ounces each of glycerine and sulphate of magnesia given high in the bowel, with half a pint of water, will sometimes turn the tide and give the patient another chance.

The diet is of great importance. It should be chiefly liquid but of the most nutritious character, and regulated closely by the patients capacity for digesting and assimilating food, instead of stuffing his stomach with more than it can manage.

The sharp pain usually present early in the attack is best met with a hypodermic of $\frac{1}{4}$ grain of morphine, but this should be resorted to only when necessary. When the cough is too severe or interferes too much with the patient's rest, codeine is the best remedy to use. A moderate cough requires no medication.

The heart and circulation should be given close attention from the start. I believe, however, that it is a mistake to give heart stimulants until they are indicated. By so doing, we are liable to destroy the usefulness of a drug that might, later, have been very serviceable. Some cases seem to require heart stimulants almost from the start, and others require none at all. As soon as there is a weakening of the first sound of the heart or any symptoms of an impaired circulation, heart stimulants should be given at once. I usually begin with strychnia, and later add a mild alcoholic stimulant if necessary. Sometimes a few doses of digitalis, combined with the strychnia does well, but it should be remembered that this drug contracts the arterioles and thereby raises the blood pressure. Consequently, it should be used with care. When the blood pressure is already high, it should not be used. When there is vascular relaxation with or without cardiac dilatation, digitalis is a good remedy to try. But it must be

remembered that digitalis is not a safe remedy to depend on in pneumonia, for the reason that in the presence of a high temperature or toxemia the drug often seems to have no effect whatever, no matter how reliable a preparation of the drug is used. Intramuscular injections of camphor in olive oil is the best treatment in such conditions. This remedy can now be obtained in a convenient and sterile form, put up in glass ampules.

Late in severe cases of the disease, when there is a rapid pulse and leaky skin, due to a relaxed condition of the blood vessels and consequently low blood pressure, a hypodermic of atropine will sometimes save life. Considering the physiological action of digitalis, right here is where we would need it, but that is exactly where it often fails. Adrenalin chloride is of assistance in such conditions to contract the peripheral blood vessels, raise the blood pressure and consequently help the circulation. If strychnia has not already been given in large doses a hypodermic of grain 1-20, is liable to act well to whip up the heart. If the circulatory failure is acute or sudden the aromatic spirits of ammonia or comp. spirits aether should be given as rapidly acting diffusible stimulants.

The blood pressure here is of great importance, Comparing it with the pulse rate gives us a splendid index to the patients condition. A high pulse rate and low blood pressure is bad, while a low pulse rate with a blood pressure something near normal is a favorable indication, regardless of the condition or amount of involvement of the lung. The severity of the case does not depend so much upon the amount of lung tissue involved as it does upon the amount of toxic products absorbed. I have seen cases of double lobar pneumonia that were comparatively mild, while sometimes cases involving a single lobe offer a great deal more impediment to the respiration and prove fatal.

Never, under any circumstances allow a pneumonia patient to sit up in bed until well under way to recovery and all fever is gone. The heart that has served us admirably throughout the disease may suddenly weaken and immediate heart failure follow.

Expectorants should never be used except in the third stage and then only when expectoration is scant. Ammon. muriate is here the best remedy to use. In cases of delayed resolution, ammon. iodide acts about the best.

Good judgment is necessary in dealing with the high temperature of pneumonia. There is greater danger of doing too much than too little. This being a disease of short duration, a high temperature cannot do harm as in diseases that continue for a long

time. Some authorities claim that the high temperature is beneficial to the patient by destroying the specific poison of the disease. Unless the temperature shows a disposition to remain above 103° I think it is wise to make no effort to reduce it. If it goes above 103° cool sponging and an ice cap are the means to adopt. The cool sponge bath is excellent to allay nervousness, even if not necessary on account of the high temperature. All antipyretic drugs at our command, at present, are absolutely harmful and should never be given in a disease where the heart action and the oxygen carrying power of the blood is of such great importance.

A great deal of work has been done in late years by scientists in an effort to produce a serum or bacterin for pneumonia, but up to this time nothing has been accomplished that has proven a benefit to the patient. It is to be hoped that before long something in this direction will be evolved that will revolutionize the treatment for pneumonia.

—o—

Functional Kidney Cast.—The removal of a diseased kidney and the retention of one whose power is inadequate to carry on the normal renal function of the two kidneys is, of course, followed by death. Such a result is almost impossible if a preliminary cystoscopic examination combined with ureteral catheterization is performed.—A. W. Nelson, in the Lancet-Clinic.

—o—

Treatment of Duodenal Ulcer.—The characteristic signs of duodenal ulcer are periodic attacks of severe pains usually appearing three or four hours after a meal and not rarely at night. The pains are generally intense and last for hours as distinguished from the pains of simple hyperchlorhydria, where relief can be much more readily obtained. The patient usually loses rapidly in weight so that a new growth may be suspected. Other symptoms are of less importance except as intermittent motor insufficiency of the stomach of marked degree during the period of the pains. Conditions which may simulate the symptoms complex of duodenal ulcer are gastric ulcer, cholecystitis, gastric crises and gastric neuresthenia with hyperacidity. In every case, internal treatment should first be tried. The patient must remain in bed for several weeks with hot applications on the abdomen and should live on milk, cream, thick gruels with the addition of butter and yolk of egg, raw eggs, with sugar, rice, farina, etc. Where internal treatment does not bring about a cure, an operation should be advised. The transverse resection of the ulcer is always preferable to gastroenterostomy.—Therap. d. Gegenwart.

THE JOURNAL OF THE Kansas Medical Society.

JAMES W. MAY,

EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1905, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President, Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

The annual meeting of the state society will be held at Topeka, May 7-8, 1913. Preparations are under way which will make this the banner meeting of the society.

The Shawnee county medical society has a committee actively at work arranging a program of entertainment. The program is being arranged by Dr. C. S. Huffman, our secretary and will include two or three men of international repute. To all those who will present papers at the meeting, kindly remember to have a corrected typewritten copy for publication in the Journal. The reason is obvious.

—o—

If you wish to be a good member of your medical society, you would first: Pay your dues promptly without having to be repeatedly reminded of the debt; attend at least a major portion of the meetings and help them to be of interest by presenting papers and taking part in the discussions; meet your fellow-men on an equal footing and give what you can from the school of experience as well as gain what you can from the experience of others; be charitable to the faults of others, remembering that you may have some over which the mantle of charity has been spread by enduring brothers; withal be as true to the profession as you would

have it be true to you. All of which will have the best of influence for all time to come.

—o—

Just before going to press your editor received a message from Dr. Crumbine saying that House Bill No. 76, introduced by Fry had been killed, but there is now a bill in the senate which has been reported favorably by a committee, which is worse than the Fry bill. It provides that the Board of Health shall consist of nine members, five of whom shall be laymen. This bill is known as Senate Bill No. 248, introduced by Senator Price of Greenwood, and should be killed.

—o—

The following letter from Dr. Crumbine speaks for itself. It has been commented upon by the president, three of the councilors and your editor:

January 21, 1913.

Dr. James May, Editor, Journal, Husted Building, Kansas City, Kansas:

Dear Doctor May:—This is to advise you that a bill has been introduced into the House, House Bill No. 75 by Hines, to legalize the practice of chiro-practics. The Bill has been referred to the Committee on Hygiene and undoubtedly will receive a fatal blow so far as that committee is concerned; but the practice usually is to appeal from the adverse decision of a committee and try to place the Bill upon the Calendar by a vote of the House.

Another bill, House Bill No. 76, introduced by a traveling representative of a certain manufacturing company of this state, provides for the re-organization of the State Board of Health; to be composed of four so-called business men, representing the manufacturers and dealers in food and drug products, four physicians and one attorney. These representatives of the business interests are there for the purpose of passing on the legality of their own products. If the attorney appointed coincides with them the doctors hands would be bound and thus the food and drugs law would, to all intents and purposes, be nullified and put out of business.

This ingenious bill also provides that thirty days after its passage the Governor shall appoint all of these new members and they shall forthwith proceed to assemble in the City of Topeka, and elect a President and Secretary. In other words, the joker

in the bill is to remove the present secretary; which it appears they are unable to do excepting by a reorganization enactment of this sort.

Those who are actively pushing this bill have behind them the men who have come in contact with the provisions of the Food and Drugs Law. In other words, chiefly the law violators who are demanding the reorganization and change in administration of the Boards' work.

Of course, it does not appear illogical to these people that the Food and Drugs Law is only one of the divisions of the work and perhaps an unimportant work so far as the life and health of the people is concerned. And yet these five laymen, including the attorney, representing the majority of the proposed board are to frame the policies of the Board of Health, along the lines of preventive medicine. They are to dictate how the division of water and sewerage should be conducted; they are to supervise the division of vital statistics; they are to advise the physicians of the state concerning antitoxins, serums and bacterins; they are to control the great sanitary organization of the state, comprising the 105 county health officers and the 10 health officers of the cities of the first class; they are to direct the secretary in conducting the summer school for physicians and health officers; and, if the present arrangement of the union between the state board of health and the University continues, they might even try to dominate the school of medicine. Of course, this is impossible, but I used it as an exaggerated illustration of what such a movement might mean.

At all events, it is clear to see that such a condition would greatly handicap, if not entirely hinder the efficient work of the state board of health, absolutely and completely drawing the teeth of the Food and Drugs Law and making a condition so intolerable that the present secretary could not for a minute undertake to continue the work.

Incidentally a proposition of that kind is a direct insult to the physicians in the state and in effect charges them with incompetency in conducting the affairs of the state board of health and declares that four dealers in pickles, and groceries and pop and sausages would place this department on the high plane of efficiency which would conserve the interests of the consuming public and the sick people of the state.

Of all the assinine propositions that were ever proposed in the Kansas Legislature, I believe this to be the limit.

Two bills have been presented to the House calling for an

amendment to the Vital Statistics Law, one of these was framed by this department and is House Bill No. 3, and the other is presented by the undertakers. It is but fair to say that the undertakers really meant to amend the bill so that it would be more convenient to them and not for the purpose of crippling the Law. There will be no difficulty in arriving at a satisfactory agreement as to the differences in the bills.

Another bill that has been introduced in both the House and Senate, provides for the proper compensation of health officers. This compensation is based upon a per capita population at five cents, outside of cities of the first class. It also provides that after 1915, no physician will be eligible to the position of county health officer unless he can present a certificate of attendance of at least one term at the Summer School for health officers, held each year at the University. The third annual session will be held in June of this year.

These are all the bills of immediate interest to the physicians of the state that have been presented up to the present time. I will advise you further of additional proposed legislation.

Will you send out the S. O. S. call to the physicians of the state, asking them to write or telegraph their representatives and senators protesting against the passage of House Bill No. 75 and No. 76? Things are moving swiftly and immediate action should be taken.

Fraternally yours,

S. J. CRUMBINE, M. D., Secretary.

—o—

THE PRESENT STATE BOARD OF HEALTH IN KANSAS.

Kansas has made a fine record through its Board of Health in the fight to prevent disease and sickness in the state and is now generally regarded as having one of the most efficient Boards of Health in any state of the Union. The credit for this is due very largely to the man who has filled the position of secretary of the Board of Health for the past six years. He has put the energy and ability into the fight against preventable diseases in the state that has made him favorably known all over the United States.

Now it is to be expected that in the discharging of the duties of the office, which includes in these duties the enforcement of the Pure Food Law, that he could not please everyone and that after this length of time he would have made some enemies. However, had he not, he would not be suitable and would not be worth keeping and through this impartial discharging of his duties he has made enemies who are now striving to get rid of him. They

know that they could not do this by sustaining any charge against him so they provide by Amendment to the Board of Health Law to change the board as now constituted. This Bill was introduced by a Mr. Frey of Junction City and is known as House Bill No. 76. It provides for a reorganization of the state board of health. The elimination of four physicians and in their places putting on four business men. If the enforcement of the Pure Food Law was the only or most important duty of the Board of Health, there might not be so great an objection to this arrangement, but to the board of health is intrusted the lives and health of the people.

In the matter of prevention of preventable diseases, this to my mind is the most important duty intrusted to the Board of Health and the elimination of one-half of the physicians now constituting that board and in their place putting in business men, certainly would not be calculated to increase the efficiency and the displacement of Dr. S. J. Crumbine as secretary of the board of health would be a calamity to the state, as he now has been in the work long enough so that in the next two years he will be able to accomplish very much more than he has ever accomplished in any two years in the time he has filled this office.

We certainly hope that the Bill will fail and that the present Board of Health Bill will remain un-amended as it now stands upon the Statute Books.

GEO. M. GRAY.

—o—

WHAT THE PROFESSION OF THE STATE SHOULD BE DOING TO PREVENT VICIOUS MEDICAL LEGISLATION.

First, The medical profession should get together and work systematically and collectively toward some definite goal! The sin of indifference is at once our weakness and our danger.

We will always find here and there a few doctors who show a lively interest in medical legislation, but the great mass of physicians either do not care or will not give the matter time for thought and action.

In order to defeat the enemy we must meet him on his own ground and use the same methods which he is finding successful. The medical man is doing a lot of altruistic work in the world; he is trying to inculcate those principles into the mind of the layman, which if carried out, would rapidly put the doctor out of business; but one can talk this thing to the average layman till he is black in the face and he will be judged from the layman's own standard of business, which are essentially selfish, and frequently sinister.]

The medical profession is not without its champions among the laity; but the average legislator is not of this class. He may be before election—but after—changes his view-point.

To my mind what we need at the present time is an aroused professional feeling, and a good strong representation at Topeka, while the Legislature is in session; men who will look after our interests and these men shall be paid well for their time and service. I would favor a special assessment of each member of the state medical society for the sole purpose of protecting our interests; someday perhaps, we may be able to place our cause with the people on that high ethical ground which we all desire, but that time is not yet here.

As long as Judges, Lawyers and Preachers will blatantly espouse the cause of an out-lawed chiropractor, a man of no general education; who formerly made a failure at horse-shoeing, and who, after a three months course in Chiro' hangs out as a full-fledged practitioner of medicine, there is little use in wasting words of a highly ethical character on such kind.

I believe we will get results when we go after them in a business-like way, and we will never obtain what we want in any other way.

O. D. W.

—o—

It is time to issue the S. O. S call to physicians of Kansas if vicious medical legislation by the present Kansas Law Makers is to be checked.

House Bill No. 75, introduced by Representative Hines, would legalize the practice of Chiropractics, (whatever that is), and in effect would put aside the ruling of the Supreme Court that those who desire to practice this form of the healing art should be subjected to the same examination as to qualifications as are regular physicians.

The most vicious piece of legislation yet attempted by the legislature now in session, is in the form of House Bill No. 76, introduced by Mr. Fry of Geary County. Listen at what Mr. Fry would do! Reorganize the state Board of Health by placing thereon four so-called "Business Men," four physicians and one attorney. Can't you see the Joker in this ingenious bill?

Why our efficient Secretary, who has injected first life into this Board and really put Kansas on the map in matters pertaining to public health would be decapitated at once by these so-called "Business Men." Think of a majority of a state board of health composed of laymen!

To say the least, Mr. Fry has an erroneous conception of the function of the board of health if he would have business men to frame the policy of the board of preventive medicine, to dictate how the divisions of water and sewerage are to be conducted, to supervise the division of vital statistics or advise the physicians of the state concerning anti-toxins, serums and bacterins.

Perhaps Mr. Fry concedes that the physician members of the board would be expected to look after these matters but would have Food and Drug inspection under better "business" management. No doubt it would be to the interest of some "business men" to have a few "business men" on the board, but we are conceited enough to believe that the people of Kansas, the benefactors of the state board of health, heartily indorse the actions of the board, strenuous as they have seemed perhaps to some "business" interests.

Every citizen of this state who thinks Kansas has an efficient board of health, should at once get in touch with his legislator, and show him how the very "teeth of the board" will be pulled if the proposed bill becomes a law.

H. B. C.

—o—

There seems to be a great stampede in certain quarters for fear the present Board of Health will get between the "upper and nether millstones" and be sadly disrupted thereby. We have, probably, one of the best secretaries obtainable and the work of the Board in the past has been for the good of the state and its well-being, mostly; but, to say they are infallible is putting it rather strong. We must admit they have made some minor mistakes. The decision against alum for preservation purposes, is, possibly one of them. Had they controlled the amount it would have been wiser. It is silly to say that once ounce of alum to a hogshead of pickeling matter is detrimental to health. This and one or two other similar decisions has caused war against the membership of the Board and the demand for its reorganization.

To show that they sometimes commit errors, we call attention to a law they insisted on passing, the gist of which was as follows: "All eggs offered for sale must be candled and all decayed or spot eggs removed. No eggs shall be shipped that contain more than 4% decayed or spot eggs." You see he can take all out and put back 4%. This bill was turned down by the committee on Public Health much to the disgust of the originator.

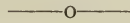
It was afterwards changed in its reading.

We are not so sure that a Board made up partially of level-

headed business men would be such a catastrophe as some seem to think, especially the present board.

We all know that the present board, outside of secretary and his assistants, are simply figureheads on most questions and could as well be done away with without any great loss to the public good. Of course they are sent out occasionally to pass about the state and draw necessary per diem; but the same work could be done by men in the office, possibly better qualified. To say that business men would thwart the efforts to control food products is far fetched. Why should they? They are not, or should not be, manufacturers of different products and would have the good of the state as much at heart, if not more so, than the present members of the board that probably meet once or at most twice a year, to do and vote as our present secretary suggests, and his suggestions are, as usual, correct. Then why worry over an imaginary "mare's nest."?

C. C. G.



Kansas has an efficient Board of Health. Upon that question there is no argument. It has done a work during the past few years that has brought favorable comment from nearly every state in the Union. This work has put Kansas on the map in public health matters.

Besides being recognized for its' great work by other states, it has received the plaudits of the inhabitants of Kansas, who have almost unanimously agreed as to its good work.

Most of those who have anything to say derogatory of the State Board of Health are the ones whose toes have been tramped upon, i. e., canned food producers, whose stock makes it necessary to use a preservative to prevent its decay, and others, whose business is not conducted along straight lines.

The proposed law has for its object the removal of five physicians from the board of health and the inclusion of five laymen, to take their place. Herein lies the danger:

These laymen who will be proposed for membership on the board will in all probability be ones whose' products have been excluded from the state—at least they would be in sympathy with them. This would take the power from physicians and put it in the hands of non-medical men. That this act would nulify the good work already done and what should be done, in the control of contagious diseases, collection of vital statistics, and work in general with this department, it is almost certain. It would mean the removal of the present secretary, whose good

work has raised the standard in health matters in Kansas to the high plane it now occupies.

The question is, can we do without the services of Dr. Crum-bine? Can we stand idly by and see the board of health shorn of its power? Answer, we cannot! Then, we should get busy, see our representatives and senators and see if we cannot kill this bill which has for its object things prejudicial to the public health of Kansas. It has been said that the doctors of the state helped to elect Geo. H. Hodges Governor, if so can we not afford to spend a little more time in politics and *help good medical legislation to get elected?*

—o—

TOPEKA MINISTER WOULD HOLD EVERY FOURTH SERVICE IN THE AUDITORIUM.

SUBJECT—PUBLIC HEALTH.

Close the churches of Topeka one Sunday evening every month, is the plan of Dr. F. L. Loveland, pastor of the First Methodist Episcopal church. Substitute for the evening church service a meeting in the Auditorium, where leaders in public health, safety and morals would tell the people the best means of dealing with those subjects. This was one of the suggestions made last night by Dr. Loveland in his sermon on "The Doctor—The Problem of Public Health."

He also took a rap at the bill to make a majority of the members of the state board of health, business men.

"Our splendid drug and food law is now being attacked in our present legislature," he declared. "By an adroit scheme to reorganize the state board of health and make a majority of the members thereof to be business men, thus giving said 'business men' a chance to pass upon the purity of its own products."

"Since beginning this series of Sunday evening sermons," he said in beginning his address, "I have been advised with becoming gravity, that such subjects as public opinion, public health, etc., should not receive treatment at the hands of the ministry. That I should preach 'Christ and Him crucified,' and not discuss questions belonging to the government. Democracy is the child of Christianity, and Christianity cannot escape her obligations to her own child. A forgetfulness of this by Christian teachers has produced the conditions in which the church finds itself today. Everywhere there is an increasing interest in practical Christianity and a decreasing interest in the church as an organization.

"During the last ten years the church has hardly held its own in the matter of growth, while Christianity has gone outside the church, and the Kingdom of God is now much larger than the church. This may be denied by those not intimate with the tendency of the times, but those who are really doing the work of the church will admit it. People smile at and pass by, the church whose definition of Christianity excludes true Christians in other churches.

"Again, the church, through her seeming inability to adjust herself to modern problems, has been practically sidetracked, and is today playing 'second fiddle' in the new orchestration of world music. The gospel of Christianity in its message to the soul, must include a ministry for the body. However much we may differ as to whether Christ was Unitarian or Trinitarian, we all agree that he was a Humanitarian. He looked after bodies as well as souls. And if the church is to regain its lost hold upon the public it must preach a gospel of good health for the body as well as for the soul.

"In the last ten years, in both medical and theological schools, the emphasis is being placed upon preventive rather than upon curative processes. Salvation by prevention rather than reformation is the new battle cry of both clerical and medicus."

"The doctors are becoming world leaders in this great movement. The most notable triumphs in the last ten years have been in the realms of preventive medicine. Typhus and enteric fevers have been banished from most of the world. Cholera and smallpox are disappearing. Yellow fever is no longer the epidemic scourge of tropical countries. Cuba is ridding itself of yellow fever. The Panama canal zone, which was once as fatal to life as the Black Hole of Calcutta, is now one of the most healthy places on the globe; all because of preventive measures. What has been done there might be done here in Topeka.

Unfortunately the church exhausts her resources in nursing and burying the victims of this fearful disease. She should lead in the campaign with the doctors for its extermination.

"The good health of our city and state should not become the victim of ignorance, business interest, nor political spoils.

"Personally, I believe the city federation of churches would be doing God's service, and certainly a service to the public, if at least on one Sunday night in every month a great public meeting should be held in the Auditorium, at which scientists and leaders of health, reform and sociological conditions, should be asked to speak upon the problems of public health, public safety and public morals."—Topeka Daily Capital.

Coming from the pulpit such a public endorsement of the efforts of the medical profession, in the promotion of public health measures, is surprising but certainly most gratifying. But then Dr. Loveland is himself a continual surprise. He is a modern disciple of an old school religion. He is a man who lives and thinks in the present and is not afraid to put into words that which he sees and which he thinks. He preaches Christianity, a Christianity adapted to the needs of a modern civilization, that goes hand in hand with good citizenship, that helps a community, a state or a nation to live better.

Addresses such as this, by men outside the medical profession, will do more to promote wholesome legislation, than all the able discussions in our medical societies and all the editorials that can be written for our medical journal.

W. E. M.

—o—

January 31, 1913.

Dr. J. W. May, Editor, Kansas City, Kansas:

Dear Doctor May—The Frey Bill for the reorganization of the State Board of Health was defeated in the House yesterday by a vote of 30 to 63. The general sentiment of the House is opposed to a reorganization of the Board of Health, but now that the Frey Bill has been defeated the opposition is concentrating its work toward pushing the Price Bill No. 248, in the Senate, which is still more radical than the Frey Bill.

It is of the utmost importance to the doctors of the state of Kansas that they use every ounce of influence of which they are capable, with their representatives and senators toward urging the defeat of this bill. It is to be hoped that no doctor will neglect his duty, and that he will immediately write his senator and representatives in regard to the sentiments of his community.

It is plain to be seen that the Food interests, which are directly concerned in a financial way, are backing this movement, and their proposition that they shall act as Judge and jury for every regulation coming before the Board of Health which concerns their interests is absurd to say the least.

The enclosed items will give you some idea of the work of the present Board of Health. Shall the people of the state of Kansas and the members of the Kansas Medical Society sit idly by and witness the abolishment of such a board?

Do not forget that Chiropractor Bill No. 97 is on the Senate Calender and will come up in a few days. It seems to be up to the doctors of the state of Kansas and it is to be hoped that no man will neglect his duty in these matters.

Very truly yours,

C. S. KENNEY. JOHN J. SIPPY.

THINGS ORIGINAL FROM THE KANSAS STATE BOARD OF HEALTH.

1. First state to inaugurate state-wide anti-fly campaign and originator of the slogan "swat the fly" now world-wide expression.

2. First state to abolish common drinking cup, now prohibited on interstate trains by federal government and twenty-seven states.

3. First state to abolish roller-towel, now forbidden on interstate carriers after March 1st, 1913.

4. First state to forbid use of ice directly in water-tanks, on railroad trains to become effective July 1st, 1913.

5. First state to establish a standard for oysters and prohibit shipments in old, filthy, wooden tubs, and compelling shipments in glazed metal containers that could be sterilized, and ice packed around instead of in the oysters, saving the consumers annually \$75,000.00. Most all of the states have since adopted the Kansas standards.

6. First state to invent a portable emergency hypochlorite plant for purifying polluted city water supply on short notice, in case of typhoid epidemic. Since adopted by many other states and countries. (Engineering news.)

7. First state to utilize the boy-scout movement in town clean-ups and anti-fly campaigns. Since has been recommended by National Organization.

8. First state to utilize the moving pictures as an educational feature in public health work. Since its utilization has become universal.

9. First state to make investigations covering one year, of the loss of weight in stored butter and flour to check up short weights. This data is now used all over the U. S. by Food Commissioners in short weight frauds.

10. First state to utilize the popular post-card in public health education.

11. First state to investigate the question of "Copper in Oysters." Now considered a classic even by the Federal Government.

12. First state to make a study of tomatoes and canned tomatoes industry.

13. First state to investigate the condition of waters served on railroad trains and stations, resulting in federal government appointing a commission for fixing a standard for "What is pure (safe) water," of which the Kansas Secretary is a member (just appointed.)

14. First state to start research work on the relation of the sand-fly to the mysterious disease pellagra (still in progress.)

15. First state to have a summer school for physicians and health officers, to train men for state service. (Third annual this year. 50 registered last year.)

16. First state to undertake a social study of vital statistics to be used for social betterment. (Now under way.)

17. One of five states that the U. S. Public Health Service grades in class A in certain phases of public health work.

18. First state to adopt civil service examination as basis of appointment of Food and Drug Inspectors.

19. First state to fix standard for medicines not standardized by the U. S. P., N. F. and other standard authorities.

20. First state to regulate the sale of deteriorated Patent Medicines. Kansas standards are copied all over the U. S.

21. Requests for Kansas Health Almanac from all over the world.

22. Kansas Bulletins used as texts in Domestic Science Departments and High Schools in several states outside of Kansas.

23. The first state to provide for quarterly inspection of all Packing House employees with regard to communicable diseases.

—o—

The present executive has the doctors of the state with him at present. He has the regular profession to thank, partially at least, for his present incumbency. Should he profit by referring some things relating to members of different Medical Boards to the State Society for nomination thereto, he will probably make no mistake thereby, and will have the regular profession supporting him solidly as a unit; but should he, like unto others in the past, ignore their strength and select cross-road politicians to fill said boards, he can expect them to fight him in the future as they did his opponent at last election, only more so.

We hope our Governor will continue wise and not fail to recognize the regular doctor, the men that are constantly trying to protect the people and thereby multiply the wealth of the state.

C. C. G.

—o—

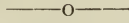
LEGISLATION REQUIRED.

The only legislation we can hope for is that there will be none. Our present medical law is probably the best that could ever be obtained and great credit is due to its originators, Dr. McDonald and other members, for its being placed on Statute books. It certainly could not be surpassed at the present time and any tinkering with its provision will probably result in its repeal.

We are going through an epoch of mental insufficiency with delusions of knowledge and belief in the supernatural, that, if not handled with kid gloves, we will have, not only Christian Scientists, Chiropractors, Osteopaths having medical boards; but even Chiropodists, Opticians, Taxidermists and all other "ists" also demanding to be turned loose on a gullible and deluded public.

Beware of the Phobia of Medical Freedom and keep what we have if we can, Selah!

C. C. G.



That mal-practice suits against physicians are on the increase, there can be no doubt. The reason for this condition of affairs is hard to explain. Certainly not because of less scientific treatment given by the physician of today for his qualifications are being raised constantly and his ability to treat patients more scientifically with greater knowledge and appliances is unquestioned. It may be laid at the door of the shyster lawyer, who instills the desire to get something for nothing in the mind of a patient who previously had not a thought of blaming the doctor. To meet this condition we must not be asleep. The state society through its' medical defense committee is doing fine work in defending these suits and the members are not slow to realize its benefits. The prevention of these suits for mal-practice is a subject worthy of thought. We should in the first place be very chary of offering criticism of anothers' work all such being eagerly taken up and magnified by the patient; their relatives and friends. It sometimes happens that physicians opinions as to the proper way of treating a case differ vastly yet each may be right. It is then not for you to judge the case of your neighbor, but simply do the best you can for the patient and be content. Do not let professional jealousy tempt you to make some remark that may be the means of starting a mal-practice suit. The Lord knows we all have failures enough at best but to ascribe it to bad medical treatment would be most unjust. Another way of preventing mal-practice suits from its moral effect was told in the Iowa Medical Journal for January by Dr. F. S. Speaman

In an editorial he says:

"Now it occurs to me that if the victims of these suits would follow the example of a doctor I knew back in the East there would soon be a decided diminution in the number of these outrages. This doctor had attended a woman in confinement, and apparently everything had gone satisfactorily. The husband and wife were, however, dissatisfied over something, and brought suit for malpractice, but when the case came to trial the doctor won. He then in his turn sued the couple for slander, and got \$3,000.00 damages, with costs, against them, which no doubt did

them more good than a year of the best sermons ever preached would have done. It might of course be objected to this that the majority of people who bring malpractice suits haven't got anything, so that it would be like trying to get blood out of a turnip. Granting that this is true, a judgment against them holds for a long time, and could be collected in case they should in the future ever have anything. But in any event they would be put to the expense of employing counsel, and would have it very quickly forced home to them that a lawyer isn't such a charitable institution as a doctor. It is very well to say that when smitten on one cheek one should turn the other, but when we do that we are in danger not only of being smitten on the other cheek, but of getting a kick on a more humble portion of the anatomy as well. This is the day of the 'big stick,' and if doctors as a class show that they will not submit to imposition any more than my friend did, they will find that impositions will cease."

This plan is a good one and should be followed. There ought to be some recourse for the inconvenience of having to defend a suit for mal-practice and this retaliatory measure might help to put a damper on others who intend to prosecute or persecute the doctor.

—O—

Certificate Before Marriage. Rev. Charles George Bikle, pastor of St. Paul's Church (Lutheran), Williamsport, has publicly announced that he will not officiate at a wedding where the contracting parties do not furnish certificates of mental and physical health signed by a physician.—Pennsylvania Medical Journal.

This plan, if followed throughout the country would be a boon to humanity. Of course to be of great service it would necessarily have to be supported by all persons qualified to perform the marriage ceremony. However, state laws prohibiting marriages unless the contracting parties had health certificates from reputable physicians would solve the problem.

—O—

Capper Not Their Only Killing—The Leavenworth Post says: "The doctors take the credit for killing Capper for governor. There are 2,500 doctors in an organization in Kansas and they all voted against Capper."

"Killing Capper as governor is not the only killing Kansas doctors have accomplished. There are about that number of doctors in Kansas who have a wider reputation for what they kill than what they cure."

The above squib which was run in last months' issue of the Journal was taken exception to by one of the associate editors who thought some comment should have been made. This little article was probably run by the Leavenworth Post in a spirit of fun, and it was reprinted in the Journal simply to show that the laity gave some credit to the doctors for bringing about Cappers' defeat.

Certainly the editor does not believe in the latter part of the statement but is willing to see a joke pulled off at his expense and be an accessory after the fact.

In commenting on the attempted assassination of Roosevelt, many newspapers have not lost sight of the seeming attempt on the part of the attending physicians to secure as much publicity as possible, and, as one paper says: "The Chicago doctors did not overlook any of the advertising possibilities incident to the case."

It is a little nauseating to the rank and file of the medical profession to note that some of the surgeons of national reputation, and especially those who have been highly honored by the medical profession, can resort to advertising tactics which, if followed by medical men of less reputation, would be severely condemned. We admit that occasionally a prominent medical man will find his name conspicuously featured in the daily press without his knowledge or consent, but such instances are comparatively rare. When you frequently see a well-known surgeon's picture in the daily newspapers, coupled with interviews, or histories, or a report of the doings or accomplishments of that surgeon, it is a safe guess that the surgeon has been willing to accept, even if he has not purposely sought, such exploitation of himself. This leads us to remark that a few of the very noted surgeons who find newspaper prominence very distasteful succeed in keeping their names out of the daily newspapers even when attending celebrated persons. This only goes to show that if a noted physician seeks or desires advertising through the public press he can secure it with but little effort on his part, and, on the other hand, if it is distasteful to him he can prevent it. But just as long as we look complacently on the censurable acts of the big fellows of the medical profession, let us throw the mantle of charity over the little fellow who does the same thing, and who usually comes in for the severest sort of condemnation if he deviates from the path of rectitude or professional propriety.—Journal Indiana State Medical Association, October 15, 1912.

Right! It seems absurd to have to call attention to faults of this character. It is amusing indeed to hear men preach ethics in one department and totally ignore them in another.

In all probability the noted physicians whose names so frequently appear in the daily press would hold up their hands in horror at the word fee-splitting, but it can be readily understood that with the business foresight of being a good advertiser, fee-splitting is entirely unnecessary. There is of course no excuse for the latter and less for the former.

—o—

THE RELATION OF THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING, TO THE SCHOOL OF MEDICINE OF THE UNIVERSITY OF KANSAS.

In the discussion of the location of the school of medicine of the University of Kansas, the influence and opinions of the Carnegie Foundation for the advancement of teaching, seems to have been overlooked. This foundation is endowed with fifteen millions of dollars. The income of this huge sum is used to pension teachers who have taught twenty-five years and have reached the age of sixty-five (or their widows): it being stipulated that they

should cease all teaching upon receipt of this pension. In administering this fund, the board in control will admit only institutions reaching a certain minimum standard. When an institution is placed upon the Carnegie Foundation, it is of immense value to it, since it enables it to obtain better men for smaller salaries than is possible without a pension system. The University of Missouri, in order to accept this pension, dropped the last two years of medical instruction. When the University of Kansas was inspected, the clinical department of its medical school was found deficient, and the entire University was refused recommendation because of this deficiency. However, their expert in medical education reported after his inspection that the opportunities were excellent; and that every effort should be made to develop a school of the first rank. He also assured the University of Kansas that as long as it maintained a medical school in Kansas City or its vicinity that the Carnegie Foundation would consider that it had preempted the territory and that no other standard University would be permitted to establish a medical department in any part of the city. This was confirmed by other representatives of the Foundation.

In the special report issued by the Foundation it was shown that thirty-one medical schools were needed to provide medical education in the United States. Of these thirty-one, Kansas and adjacent territory were given one; and it was pointed out that only one good medical school could be maintained and supported in this territory; and, that Kansas City was the logical situation for the school. In other words, according to expert opinion, the University of Kansas now has the opportunity to build up one of the greatest medical schools in the country, with Kansas City as a logical center. If the University of Kansas should withdraw from this city, another school will immediately be established here. Of that fact, there is not the slightest doubt. If the University of Kansas should withdraw to Lawrence or Topeka, the stronger school would then be developed in Kansas City because of the greater supply of clinical material. The result is evident: In the course of a few years the clinical department of the school of medicine of the University of Kansas would gradually die. The University of Kansas would give its students the first two years of their training; and the state of Kansas would then be dependent upon an outside institution for the education of its future physicians. The University of Kansas would have lost its great opportunity; for this territory cannot support two good medical schools.

J. E. SAWTELL.

A New Ether Dropper—Dr. W. R. Heylmun, Iola, Kansas.—This dropper will be found to have the following advantages: It is inexpensive. It is so simple that it can be made by anyone on short notice, it economizes ether by doing away with the spurt- ing that occurs when the anesthetic is used directly from the can with a puncture in the cap. It insures a smooth, even drop, so that the amount of ether can be easily regulated. After the anes- thesia is finished, if ether remains in the can, it may be effectually sealed and set aside to be used again in the same manner, and with the same dropper.

To make this dropper, proceed as follows: Get a child's hollow rubber ball, about one and a half inches in diameter, smooth and pliable, such as can be found at any toy shop for five cents. With scissors cut the ball into two equal parts. Take one of the parts and cut a hole in the bottom, a little smaller than the neck of the can on which it is to be used; then cut a slit about a half inch long each way from the center of the hole, this makes a but- ton-hole so that it will slip over the mouth of the can and still grasp the neck securely. Having placed the rubber on the neck of the can in this manner, cup turned upward, puncture the metal cover over the mouth of the can with a pin, lay a wisp of cotton across the mouth of the can with one end extending beyond the rim of the cup, bring the edges of the rubber together in line with the wisp of cotton, and fasten with three or four narrow strips of adhesive plaster.

The dropper is now ready for use. The flow is regulated by tilting the can. When the anesthesia is finished, if ether remains in the can, drop a pin into the puncture, cover the top with a piece of plaster and set away for future use. The same piece of rubber can be reconstructed into a new dropper indefinitely.



A New Ether Dropper.

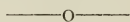
SOCIETY NOTES.

2nd District, C. C. Goddard, councillor, Leavenworth:

The annual banquet of the Wyandotte County Medical Society was held at the Grund Hotel, Kansas City, Kansas, January 7th. This annual jollification is always looked forward to by the doctors and it does more than all else to prompt friendship and good feeling among its members.

This year covers were laid for ninety and the society had as its guests Chancellor Strong, Dr. S. J. Crumbine, Dr. Chas. S. Huffman and Dr. C. C. Goddard, who responded to toasts. Governor Hodges was to have responded, but being unable to be present his secretary, Grant Harrington represented him. Others on the program were Hon. Henry E. Dean, City Commissioner and James W. May.

Dr. George M. Gray the retiring president in a happy vein administered the oath of office to the president-elect, Dr. W. F. Fairbanks. Dr. Fairbanks presided and his introduction of the speakers was the hit of the evening.



At the regular meeting of the Wyandotte County Medical Society, January 21st, the following program was given:

Report of Two Cases of Tumor of Caecum, Dr. R. C. Lowman.

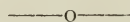
Report of Appendicitis Cases, Dr. Geo. M. Gray.

Report of a Case of Tubercular Kidney, Dr. J. A. Fulton.

Surgical Tuberculosis, With Report of a Case, Dr. W. S. Sutton.

Report of a Case of Placenta Membranacea, Dr. G. L. Hamilton.

J. F. HASSIG, Sec'y.



5th District, W. E. Currie, councillor, Sterling:

Program of the Harvey County Medical Society for February:

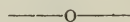
"DISEASES OF CHILDREN."

"Tubercular Joints," Dr. L. T. Smith.

"Cerebro-Spinal Meningitis," Dr. J. W. Graybill.

"Intussusception," Dr. J. T. Axtell.

Review of Recent Literature or Report of Case, Dr. A. E. Smolt.



The officers of the Harvey County Medical Society for 1913 are: President, R. H. Hertzler, vice-president, J. L. Grove, secretary-treasurer, F. L. Abbey. Delegate to State Society, A. E. Smolt.

Reno County Medical Society met at Hutchinson December 27. A good program was prepared and well discussed.

Butler County Medical Society met in ElDorado, December 19, 1912. Fifteen Butler County physicians attending and participating.

A paper Peri-Nephritic Abscess was read by Dr. H. A. Hill of Augusta. Discussion by Dr. N. E. Wilson of Douglass. Dr. C. E. Hunt of ElDorado, Dr. John Allen of Latham and Dr. J. R. McCluggage of Augusta.

Dr. W. O. Bennet of ElDorado read a paper entitled "Advertising Doctors", which elicited a general and spirited discussion.

The following were elected (or rather re-elected) officers for the ensuing year: Dr. F. A. Garvin of Augusta, President; Dr. R. B. Earp of ElDorado, vice-president; Dr. J. R. McCluggage of Augusta, secretary-treasurer. Dr. C. E. Hunt of ElDorado, Dr. W. O. Bennett of ElDorado and Dr. J. R. McCluggage of Augusta, board of censors. Dr. J. R. McCluggage of Augusta, delegate to the state medical society and Dr. Anna Perkins of ElDorado, alternate.

The following were elected to membership in the county society: Dr. G. A. Sperry of Towanda, Dr. F. D. Stinson of Douglass, Dr. W. W. Weber of Leon and Dr. Wm. McKinney of Latham.

A resolution requesting our senator and representative-elect to support our present medical practice act, also the proposed bill for the appointment and compensation of the county health officers. I enclose copy of resolutions. Next meeting ElDorado, February 20th, 1913.

J. R. McCLUGGAGE, Sec'y.

Resolutions adopted by the Butler County Medical Society at the regular meeting held in the commissioner's room of the court house in ElDorado at 2 o'clock, p. m., December 19th, 1912.

Whereas, The chiro-practors, magnetic healers, patent medicine Vendors and other classes of medical fakers have combined under the catchy name of "League of Medical Freedom", to secure the repeal or modification of the present law regulating the practice of medicine in this state, and whereas, we believe that such change would be detrimental to the welfare of the public, and

Whereas, The duties and responsibilities of the local health officers have been greatly increased by the enactments of the legislature in recent years, and

Whereas, We believe that better service can be secured to the public by taking this office entirely out of politics, and

Whereas, This society has given careful consideration to the appropriation asked for by the State Board of Health, giving attention to each item separately, and believing that the total amount asked is very reasonable for the efficient service rendered the public by the board, therefore be it

Resolved by the Butler County Medical Society, That we respectfully request our senator-elect and representative-elect to oppose any change or modification of the present Medical Practice Act.

That we urge them to support the proposed bill for the appointment and compensation of County Health Officers.

That we request them to use their best efforts to secure the appropriation of the full amount of money asked for by the State Board of Health. Be it further

Resolved, That a copy of these resolutions be forwarded to Hon. J. D. Joseph, senator-elect; and to W. J. Houston and J. M. Satterthwaite, representatives-elect, by the secretary of the Butler County Medical Society, who is hereby authorized to append our names thereto.

The above resolutions were adopted unanimously.

J. A. McCLUGGAGE,
Secretary Butler County Medical Society.

—o—

6th District, Arch D. Jones, councillor, Wichita:

The Elk County Medical Society held a meeting for the purpose of election of officers for 1913, December 18, 1912, at secretaries' office, Howard, Kansas.

Dr. F. K. Day read a very interesting paper on his experience with "78 Congestive Cases of Confinement."

Members present: Dr. Clinton Beasley, Moline; Dr. F. K. Day, Longton; Dr. Burgess B. Mason, Grenola; Drs. J. F. Costello, J. L. Hay, R. C. Harner and F. L. De Pew, Howard.

Officers elect: President, J. F. Costello, Howard; vice-president, R. C. Harner, Howard; secretary-treasurer, F. L. De Pew, Howard; Censors, 2 years, Clinton Beasley, Moline; 1 year, F. K. Day, Longton.

This was the best meeting in two years.

F. L. DE PEW, Secretary.

—o—

The annual meeting of the Sumner County Medical Society was held at Wellington, December 19. The following officers were elected: President, H. A. Vincent, Perth; vice-president, R. A. McIlhenny, Conway Springs; secretary-treasurer, H. F.

Hyndman, Wellington; censors, W. H. Rea, Oxford; delegate to state society E. A. Evans, Conway Springs.

The society endorsed the budget of the state board of health to the legislature. The following new members were taken in: R. E. Baker, Belle Plaine; E. F. Clark, Mayfield; T. G. Burris, Conway Springs; G. E. Egloff, Corbin.

After the business meeting the society adjourned to the Antlers Hotel, where a banquet was held. The following program was given.

President Dr. Emery Trekel, toastmaster.

Progress—Walton Rea.

Sumner's Son—H. G. Shelly.

Doctors in Politics—J. J. Sippy.

My Trip Up Salt Creek—Jno. C. Caldwell.

Kansas—Geo. Knappenberger.

New Members—E. F. Clark.

Our Latest Citizens—Mrs. M. Collins.

—o—

7th District, W. F. Sawhill, councillor, Concordia:

At the regular meeting of the Cloud County Medical Society, held at Concordia, January 21st, the following symposium on "Diseases of the Kidney," was given:

Acute Parenchymatous Nephritis, Dr. S. C. Pigman, Concordia.

Chronic Parenchymatous Nephritis, Dr. Chas. Stein, Glasco.

Chronic Interstitial Nephritis, Dr. W. F. Sawhill, Concordia.

Pyelonephritis, Dr. F. A. McDonald, Concordia.

Nephrolithiasis, Dr. W. A. Farr, Miltonvale.

Ocular Manifestations in the various forms of Nephritis, Dr. E. N. Robertson, Concordia.

Case reports and general discussion.

Resolutions were adopted endorsing the State Registration Law for Nurses and the Vital Statistics Law, but recommending that the latter bill be amended so as to allow a small compensation to physicians for making reports, in order that the work may be done more carefully.

Two new members were taken into the society; Dr. W. R. Palmer of Glasco, and Dr. F. J. Moffatt of Clyde.

E. N. ROBERTSON, Sec'y.

—o—

8th District, O. D. Walker, councillor, Salina:

At the annual meeting of the Saline County Medical Society the following officers were elected for the year 1913:

President, O. R. Brittain, Salina; vice-president, E. R. Cheney, Gypsum; secretary, H. W. Moses, Salina; treasurer, C. M. Jeremy, Salina.

Paper—"Pregnancy in Association with Appendicitis", Dr. W. S. Harvey.

Paper—"Puerperal Eclampsia," E. W. Hawthorne.

Paper—"Cancer," E. R. Cheney.

The meeting was held at Gypsum. After the program the doctors were entertained to a sumptuous dinner at the home of Dr. Cheney, at which the wives of Drs. Cheney and Hawthorne did the honors in a most gracious manner.

O. D. WALKER, Sec'y.

—o—

9th District, C. S. Kenney, councillor, Horton:

The Ninth and Tenth councillor districts have perfected their organization and have elected officers. The meeting was held at Norton on January 9. The meetings will be held annually at Norton in October. Officers elected for 1913:

President, F. H. Smith, Goodland; vice-presidents, F. A. Relihan, Smith Center; I. B. Parker, Hill City; secretary-treasurer, C. W. Cole, Norton; censors, R. B. Stoner, Quinter, John Jeurinck, Prairie View; E. D. Beckner, Hoxie.

The object of this organization is to unify the profession in this part of the state, and to give those who desire, a chance to join the district society in case there is no local society.

—o—

NEWS NOTES

The Medical Society of the Missouri Valley will meet at Kansas City, Mo., March 20-21, 1913. One day of clinics will be held at the General Hospital. An invitation has been extended to physicians of adjoining states to attend.

—o—

The regular meetings of the board of medical registration and examination are held on the second Tuesday in February, June and October of each year, at Topeka.

—o—

Dr. W. C. Lathrop, who has been practicing his profession in Salina for the past six months has returned to Norton. He is located in his former suite of rooms in the Marsh Block.

—o—

Dr. C S Kenney has been appointed Superintendent of the State Tuberculosis Sanatorium being constructed at Newton.

He will leave Norton early in the spring to assume charge of that institution.

—o—
Dr. W. F. Fairbanks, president of Wyandotte County Medical Society, spent January on a pleasure jaunt in Florida.

—o—
Dr. C. L. Zugg has moved his office from Kansas City, Kansas, to the Gloyd Building, Kansas City, Missouri.

—o—
Dr. C. M. Stemen of Kansas City, spent 4 weeks traveling in the west for pleasure.

—o—
During the fiscal year ended October 23, 1,500 patients received treatment at the Bell Memorial Hospital, Rosedale, which is conducted by the University of Kansas.

—o—
Dr. H. L. Aldrich of Caney, president of the State Board of Health, has recently been elected coroner of Montgomery County.

—o—
Dr. J. A. Davis took the oath of office in January, as coroner of Wyandotte County.

—o—
Wichita Hospital.—Wichita is making an earnest effort to secure \$100,000 for a new and modern hospital and in the first two days of the campaign more than \$13,000 was raised. An anonymous donor presented the entire equipment for the delivery room of the obstetric department.

—o—
Dr. E. A. Bodenbamer and wife of Wichita, returned after an eight months trip in the mountains of Colorado and New Mexico.

—o—
Dr. Geo. E. Egloff has moved to Corbin, Kansas, where he will continue in practice.

—o—
The Northeast Kansas Medical Society will meet at Kansas City, Kansas, February 6th. The meeting will commence at 9:30 a. m., and will be held in the mercantile club rooms.

OBITUARY.

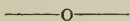
Dr. J. M. Gray, formerly of Sterling, but recently located in Hutchinson, died at his home January 5th. Death was due to pneumionia. Dr. Gray was a graduate of Keokuk, Iowa.

REVEIWS.

Colds in Children.—T. S. Southworth, New York (Journal A. M. A., November 30), says that recent years' experience has taught him to respect the common infectious cold as far from a trivial affection. Its bacteriology is yet uncertain and we may have several organisms to contend with. Infants appear to be especially susceptible to these infections and when it invades a household it is likely to go through several members. In institutions where they care for children it spreads with great rapidity, and as sequels ear disease is common, pneumonia rather less so but not infrequent. The most frequent injury, however, is inflicted by their influence on nutrition, especially in bottle-fed infants. We are apt to look on these as colds as trivial, when they are in reality systemic infections. Such colds are an unfortunate handicap in conducting feeding cases in private practice and digestive disturbances caused by them are common. The loss of weight leads the nurse or mother to over-feed the infant. Household infections are shown by returning attacks during the colder months, and they may occur also in the warmer seasons. The amount of injury done to young children can scarcely be estimated, especially in oral and sinus complications. Traveling on trains, children's parties, dancing schools, etc., are frequent methods of exposure, and Southworth emphasizes the importance of this risk. In treating a case isolation is often difficult unless the child is confined to bed and this aid is lost during convalescence. He does not consider it, however, impracticable, and if parents could realize the greater danger from this cause they would enforce it as they do in cases of the regularly recognized contagious diseases like diphtheria, scarlatina and even mumps and chicken-pox. It is a comparatively simple matter for the physician to acquaint the mother with the risks incurred and to advise her to keep those having the slightest cold from contact with other children. But Southworth knows of no text-book that teaches the danger of the common infectious cold and no medical school or health board which has taught or enforced precautions against this contagious disorder.

High Percentage Albumin Feeding.—F. C. Neff, Kansas City, Mo. (Journal A. M. A., December 21), gives his experience with a modification of the Finkelstein albumin milk method of infant-feeding. He calls his preparation high percentage albumin milk, which is made of a quart of churned-up artificial butter-milk, made with a lactic-acid ferment and re-enforced by the

addition of the precipitate, fat and casein from a quart of sweet milk. The object was to obtain a milk that could be used in a transition from Finkelstein's formula or from buttermilk. It has a higher sugar, casein and caloric content than Finkelstein's albumin milk. The infants on which it was used were all under 6 months of age at the time the feeding was begun. All were continuously observed. Many of them had not gained on breast-milk and none on sweet milk. All had shown stationary weight; most of them had had undigested stools and many had various degrees of atrophy. Sixteen cases in all are reported. The results are given as follows: "Just why the high percentage in this buttermilk mixture which I am using has been easily tolerated, as evidenced by the uniformly good stools, frequent gain in weight and absence of fever, is hard to say, but the reason probably lies in the increased digestibility from the presence of buttermilk and from the freedom of overfeeding by caloric control, while at the same time the infant is getting sufficient. Heim and John, however, at Budapest, have recently reported good results from the use of a casein-enriched sweet milk. Nine of the sixteen patients showed good gain in weight, a few of these being quite marked. Two showed loss and two only slight gain. One of the former was the most atrophic in the series. In all of the cases the good effect on dyspeptic stools occurred. Three infants remained constipated. As long as the infant continued to gain it was kept on this food. Some gained with or without addition of sugar." A tabulated statement of these results is appended to the paper.



A Simple Method of Appendicectomy.—Van Hook, (Medical Councillor), states most sententiously that every surgeon of some experience, and even those who are comparatively new in the work, can carry out the following suggestions for removing the appendix, at first in uncomplicated cases, and later in complicated ones:

1. Make an oblique incision $\frac{3}{4}$ of an inch long over the appendix; carry the incision through the aponeurosis of the external oblique muscle, which is recognized by the fact that it can be felt with the left forefinger as well as by the knife point with which it is scratched.

2. Separate with the left forefinger and an artery forceps, held in the right hand, the fibers of the external oblique, internal oblique and transversalis muscles, keeping in mind the direction in which their fibers run. Do not cut these fine fibres, but merely separate them.

3. Push a hole through the peritoneum with the left forefinger or, if the connective tissue and peritoneum are too tough, lift them with an artery forceps and cut a hole in the peritoneum with scissors.

4. Find the appendix with the finger-tip by touch. It feels somewhat like a fishing worm. Lift it with an artery forceps passed down by the side of the finger. If you do not close the artery forceps too tightly you will not crush the organ.

5. Having drawn out the appendix, crush and ligate the mesenteriolum.

6. Cut off the appendix between two pairs of artery forceps, and whip over the cut stump of the appendix with a silk or catgut suture.

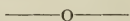
7. Having removed the forceps from the stump, turn in, with intestinal sutures, the peritoneum about the wound in the cecum.

8. With the left forefinger in the wound, feel for the slippery peritoneum, draw up its edge by friction with the finger, grasp it with an artery forceps, and lift it up into the wound far enough to stitch together with a catgut suture.

9. Lift the muscles of the abdominal wall in the same way, and insert catgut stitches in two layers.

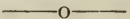
10. Close the outer wound with two silkworm stitches.

11. Patient to sit up next day after operation, if there is no wound complication, and leave hospital in six to ten days.—American Medicine.



Auto-intoxication, Tuberculosis and Rheumatoid Arthritis.—

Mr. W. Arbuthnot Lane says that in a patient affected with tuberculous or rheumatoid arthritis, chronic intestinal stasis always exists and it can be demonstrated clinically and by the use of bismuth and x-ray. For instance, in a case which was admitted into the Hospital for Sick Children, under his care as tuberculous disease of the knee-joint, the clinical symptoms of chronic intestinal stasis were absent. The administration of bismuth and radiography proved that the contents of the intestinal tract were not delayed in their progress. A Wasserman reaction showed that the child was syphilitic, and the knee reacted at once to salvarsan.—British Medical Journal.



MISCELLANEOUS **THE CHICAGO TRIBUNE BELIEVES;**

“That the kind of help given the farmer for his stock should be given him for his family.

"That communities should be helped to banish consumption and typhoid fever.

"That mothers should be protected during child-bearing.

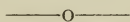
"That the slaughter of the innocents should cease as far as it is possible to make it cease.

"That children should be given a chance to grow up in strength.

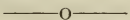
"That men should be enabled to labor at high efficiency.

"That prevention should replace cure.

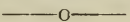
"That pauperizing of men by charity should give place to a scientifically developed scheme for the care of those who need to be cared for along broad economic lines."—Iowa Medical Journal.



Medicine in the Twentieth Century.—The nineteenth century worked for the individual. One by one each disease was investigated and the results applied to the relief of the individual patient. The twentieth century starts out with a broader conception of the function of medicine. It is working for the masses in the prevention of disease. Care of the public health has become the most important duty of the state.—Mayo in Boston Medicine and Surgery Journal.



The Physician As An Adviser.—By virtue of his greater acquaintance with worldly affairs and the position he holds of viewing a young man's qualities in the abstract, the physician is not overstepping his position in directing the youth to a proper calling. When physical conditions should not permit violent or the usual school-boy exercises, he should be warned of the ill effects of such and a proper line of pleasurable sports be laid out.—E. T. Bush, New York State Journal of Medicine.



Misinformation on Sexual Laxity.—Those who believe that sexual indulgence is a necessity may not intend to encourage immorality and venereal disease, but that is apt to be the result of any process of making excuse for sexual laxity. If he is correctly quoted, some recent words of Mayor Gaynor of New York will have a similar effect. Because of his general reputation for humanity, philosophy and intelligence, we regret to see him giving currency to mischievous errors of fact. Speaking to the forum of the New York University, he is reported by Collier's as having said that irregular relations between unmarried men and women are "not forbidden by any law here or anywhere else in the world." Collier's stamps this statement as false by pointing out that actually such relations constitute "a criminal offense

in thirty-nine states." Again Gaynor: "But in a few states of the Union they have a law making adultery a criminal offense. But it is a dead letter. Who is prosecuted for it? Nobody." Again Collier's replies: "Actually, only three states in the Union have failed to declare adultery a crime. Reports show that convictions under both these laws is obtained in three-fourths of the states." It is one thing to express opinion as to the wisdom of these statutes; it is a different and a very serious thing to speak falsely concerning the facts and thus to mislead hearers and readers into thinking that the law-makers of our country have failed to set the seal of criminality on illicit intercourse.—Journal A. M. A.

Suggestion and Suicide.—That the suggestive effect of reading details of suicides is a powerful factor in the causation of suicide among susceptible persons is recognized. The suggestion is more likely to have influence when in the account of the suicide some poisonous article commonly found in households, such as phenol, lysol and rough on rats, is named as the agent employed by the suicide. In New South Wales newspapers have been asked by pharmaceutical board not to publish the names of poisons used by suicides. In several instances leading newspapers have heeded this request, particularly in connection with lysol poisoning cases, which are numerous in all the states of the commonwealth. The American Medical Association in 1910, adopted resolutions to the effect that the publication of details of suicides in newspapers is one of the potent causes of other suicides through suggestion, and it was recommended to the public press that the details of suicides be omitted from publication. While it is the consensus of opinion that the publication of details of suicides does promote further similar acts, the newspapers assert that it is their duty to publish the news. In adopting this attitude, says The Journal of the American Medical Association, the newspapers are assuming a serious responsibility. A definite and strong expression of public opinion against this practice would no doubt have a better effect even than legal enactments.

Diabetes Mellitus.—I am undertaking an exhaustive research into the pathology, etiology and dieto-therapy of diabetes mellitus. I am very anxious to hear from every physician in the United States who has a case under treatment, or who has had any experience in the treatment of this malady. Von Noorden says "the best treatment for the diabetic is the food containing the greatest amount of starch, which the patient can bear without

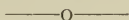
harm." If any physician who reads this has similar or contrary experience, and would take the trouble to write me, I would esteem it a special privilege to hear from him, if only a postal card.

Kindly address,

WILLIAM E. FITCH, M. D.

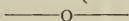
355 W. 145th St.,

New York, City.

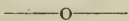


CLINICAL NOTES

Pulmonary Edema.—Many a "doomed" case of pulmonary edema, from heart disease, acute pneumonia or nephritis gives the lie to a fatal prognosis, if you know how to utilize powerful and repeated subcutaneous doses of the double salt of caffein, or a few big doses (10 to 15 minims.) of a good fluid-extract of digitalis, or strophanthin intravenously with or without good hypodermic doses of camphor in sweet almond oil, or big doses of musk or sufficient doses of a nitrite. Only those of us who do not know what medicine can do deny their efficacy.—Jacobi.



The following is a simple and usually satisfactory operation for ingrown toe-nail, that has progressed beyond palliative treatment: Beginning at the free margin of the nail about a quarter of an inch from the offending side, with straight, strong, narrow-bladed, probe-pointed scissors cut through the length of the nail and continue under the skin, directly through the root. With forceps loosen and lift out the narrow segment of nail and nail root complete. Be sure no fragments remain. The operation is brief and the pain, even if no anesthetic is used, is not very severe. Lightly pack the narrow wound. If there is much infection apply a wet dressing, otherwise a simple pledget of gauze fastened with adhesive strips. The patient can at once walk with comfort in his street shoes, and the after-treatment is trifling.—American Journal Surgery.



Early Operation for Cleft Palate.—The proper time to operate for cleft palate is as soon after birth as possible. Nothing is gained by delay except the consequences of faulty nutrition. The plasticity of the new-born tissues, their capacity for repair, the trifling hemorrhage, the slight risk to life, the possibility of obtaining a broad, well-vascularized flap before the teeth have begun to encroach upon the mucous membrane, combine to make early infancy an opportune time for repairing this defect.—W. F. Campbell, American Medicine.

Urinary suppression in infants is a condition that is so rare that, as a rule, it is advised to exclude the probability of a mechanical obstacle to the urination; or, of a congenital deformity, by the passage of a soft rubber catheter. This exact method of determining the condition should never be forgotten.—American Journal Dermatology.

—o—

Infections of Fingers and Hands.—1. Never hunt for pus with a probe in this portion of the body, as it may spread infection.

2. An incision should be made through the point of infection, giving free drainage.

3. If pus is secreted about or in the joint of a finger, pressure on the end of the finger will give rise to pain, while if the pus is in the sheath of the tendon, the same pressure will cause little or no pain.

4. The tendon should never be laid open from end to end as this procedure is almost certain to cause sloughing of the tendon.

5. If the tendon sheath is exposed and found distended with purulent or sero-purulent fluid, it should be freely drained.

6. If the whole tendon sheath is distended with pus it will be necessary to drain its upper end. Incisions for this purpose in case of the index middle, or ring fingers should be made in the palm of the hand directly over the tendon involved.—H. B. Garner in the Detroit Medical Journal.

—o—

Cancer Not Necessarily Painful.—The symptom which more preeminently characterizes the early stages of cancer of the cervix is bleeding, bleeding between the periods, or some discharge containing blood in between the periods. At that time there is no pain whatever in cases of cervical cancer. Remember that, because the public mind associates pain with cancer, and the patient is apt to think because she has no pain that therefore, no matter what the trouble is, it is not likely to be cancer. But there is no more dangerous fallacy. For a long period, in fact, as long as the disease remains limited to the cervix itself, the patient has no pain at all. It is not until the disease begins to spread beyond the limits of the cervix that you begin to find the patient has pain. So do not be misled. Any unexplained bleeding, any bleeding, occurring between the periods—if we take a patient during menstrual life, or still more definitely, any bleeding occurring after a definite menopause has been established—is extremely suggestive of cancer.—Arthur H. N. Lewers in Clin. Jour.

THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, MAR. 1913.

No. 3

THE WASSERMANN REACTION IN RELATION TO THE DIAGNOSIS AND TREATMENT OF SYPHILIS.

LINDSAY S. MILNE, Professor of Medicine, Medical Department
University of Kansas, Rosedale.

Read before the Wyandotte County Medical Society, February 4, 1913.

In recent years one of the greatest and most revolutionary advances in the field of medicine has been marked by the adoption of the Wassermann reaction in the diagnosis and treatment of syphilis. It has necessitated the most extensive revision of many of the previous conceptions of the disease. It has enormously diminished the scope of various disease conditions whose etiology has hitherto been obscure, and which we can now definitely ascribe to syphilis and can therefore treat more scientifically. By its aid, the definite relationship of syphilis to the so-called parasymphilitic lesions has been established. It further has proved of immense service in the differentiation of doubtful cases, such as ulcers, growths, and various bone diseases. Greatest of all, however, its value, one may say necessity, in the treatment of syphilis has been abundantly demonstrated. It has proved a method by which the success or failure of therapeutic measures can be determined, and without which the treatment of syphilis is most uncertain and has to be conducted entirely in the dark.

As this reaction has naturally therefore assumed such an importance in the practice of medicine, it may be of value to summarize its present position in relation to the diagnosis and treatment of syphilis.

Even at the present time different authorities report considerable variations in the results of this reaction. Its technique is being almost continually modified with rather conflicting results, and the exact interpretation that can be placed on its application to the diagnosis and treatment of syphilis has not yet been

made sufficiently definite. The result of this has been to create a very considerable amount of uncertainty about its reliability and its exact relation to the different manifestations of syphilis.

Even for a series of supposedly normal individuals the results are disputed, an average of positive results being obtained in 0.3 to 1.2 per cent of such cases, although Noguchi reports as high as 3.6 per cent. These figures, of course, depend on the method by which the technique of the reaction is conducted and also on the class of cases examined, as many who eventually show definite syphilitic lesions can give no history of the earlier stages of the disease.

Indeed, we are driven to the conclusion, both from the blood examination, and the development of tertiary lesions as the first apparent manifestation of the disease that syphilis may be acquired particularly in women without the patient ever having been aware of any primary sore or secondary eruption.

In the primary stages of syphilis the number of reactions varies in the reports of different authorities from 64 to 92 per cent. In spite of these wide reported variations it is certain, however, that in most cases a positive reaction can be obtained by the end of the fourth week, as a definite diagnosis of the disease can generally be made a week or two before the appearance of the secondary eruption. In about 40 per cent of cases the Wassermann reaction is positive when the initial sore appears, and the number of positive reactions becomes progressively more frequent until the development of the secondary eruption, at which time over 90 per cent are positive. The earliest occurrence of a reaction is reported by Lesser, who found the serum positive as early as the eighth day after exposure. In this case the initial lesion appeared fourteen days later, and was followed six weeks afterwards by a typical roseola. In my experience in about 9 per cent of untreated cases the reaction did not become positive until the first or second week after the development of the secondary eruption.

Clinical evidence seems to show that with the development of a positive Wassermann reaction the general systemic invasion of the syphilitic virus takes place. Experimentally also it has been demonstrated that with the occurrence of a positive reaction the lymphatic glands and other tissues of the body become capable of transmitting the disease to apes. As a rule therefore, the syphilitic infection is systemic sometimes before the development of the secondary eruption, and in a large percentage even before the development of the initial sore. This fact has long been recognized, an excision of the primary sore in many cases did not arrest the course of the disease.

In secondary syphilis, positive results are reported from 80 to 100 per cent. One may, however, say that practically every untreated case gives a positive reaction early in this stage, although its appearance may occasionally be delayed until one or two or even three weeks after the appearance of the secondary eruption.

In the tertiary stage, positive reactions are reported in 60 to 100 per cent of cases. The figures in this stage of the disease, although they vary considerably, depend chiefly on whether the syphilitic process is active or healed. In all tertiary lesions about 75 per cent give positive reactions. In the negative cases the disease is stationary as the virus has become eradicated and only the effects of the damage remain. It cannot, therefore, be held that because a reaction is negative that the disease is not the result of syphilis.

The most constant results are undoubtedly in secondary and hereditary syphilis. In congenital cases almost all give a positive result, even at birth (95 per cent or over.) That this is of practical importance is obvious, as many children after birth develop snuffles, and a positive Wassermann reaction both confirms the diagnosis and indicates that active treatment should be instituted at once. It also assists therefore in clearing up the diagnosis of still-birth and habitual abortions. In the majority of apparently healthy women, the mothers of syphilitic children, there is a positive reaction. Similarly, the children of syphilitic mothers are not immune to syphilis, but, as can be shown by the Wassermann reaction, are either syphilitic or healthy, or may later become infected. Thus a woman having given birth to a syphilitic child, and having a positive reaction, contrary to Colles' Law, is to be considered as having latent syphilis, and should be given specific treatment. Also a positive reaction in the child of a syphilitic mother, even though the child looks healthy, indicates that it, as well as the mother, ought to be actively treated. It is also a remarkable fact that the mothers of syphilitic children even though they present a strongly positive reaction not uncommonly have noticed up to that time no external manifestations of syphilis.

Pregnant women who have had a previous history of abortions or still-births, and who are found to have a positive reaction, should be given anti-syphilitic treatment, and in this way the next child born may be healthy.

In relation to the choice of wet nurses, the importance of this reaction is obvious.

After the clinical signs of syphilis have disappeared, many

cases, although apparently in good health, remain in what has been termed a latent syphilitic condition. Reports in this phase of syphilis average about 65 per cent of positive reactions in the early latent stage, and as many as 47 per cent in the late stages. These figures are naturally subject to the widest variation, as the treatment of syphilis has been so irregular in efficiency. Even in untreated cases it is difficult to estimate exactly how many may become spontaneously cured, how many will go on to a latent stage, how long this will last, and whether it will lead to the late manifestations of syphilis, such as aneurysm, tabes, and paresis. By means of the Wassermann reaction the existence of latent syphilis may be recognized and adequate anti-syphilitic treatment commenced. In this way the modern methods of treatment, which are guided by serum tests, have materially lowered the percentage of cases of syphilis, which have gone on to a latent stage. So, also in direct proportion has the incidence of the late manifestations of syphilis been reduced. If efficient treatment could be conducted early in every case of syphilis, very few indeed would exhibit a latent stage or any later lesions.

It is not uncommon to find cases, even when treatment has been fairly thorough, where the reactions remains positive for ten or fifteen years after infection, and some even after forty years.

In this latent stage of syphilis although there are no clinical manifestations which are obviously syphilitic, some of the most brilliant therapeutic successes can sometimes be obtained, as commonly such cases become extremely anemic, and often are the subjects of certain vague nervous, circulatory or digestive symptoms which usually disappear rapidly under anti-syphilitic treatment.

It has generally been considered that syphilis confers immunity for life, yet we know that the reason for this idea is that in insufficiently or untreated cases the disease tends more or less actively to persist for a long period after it is acquired. Reinfection with syphilis occasionally occurs, only rarely after mercury treatment, but not uncommonly after intensive salvarsan treatment combined with the administration of mercury, a fact which farther demonstrates the comparative inefficiency of the older methods of treatment. So far as I know, reinfection has occurred in no case presenting at the time a positive reaction. Certainly apes resist the development of syphilis so long as the reaction remains positive.

In the late manifestations of syphilis, such as the so-called parasyphilitic lesions, perhaps more than in any other relation, the

Wassermann reaction is called on for discriminating diagnostic tests, and is also of special use in indicating the line of treatment which may arrest the progress of the disease. The importance of any reaction which can aid in distinguishing a gumma from other forms of cerebral tumors is undisputed. Thus, as a general rule, no case of operation for cerebral tumor should ever be undertaken without a negative Wassermann reaction, and in all cases of epilepsy starting in adult life this reaction is also suggested.

Tabes and general paresis as judged by the prevalence of positive reactions in these cases, are not then parasymphilitic, but metasyphilitic or truly syphilitic lesions. This does not mean that all cases presenting tabetic symptoms are syphilitic in origin, as undoubtedly ergotism, anemia, pellagra and a great variety of other conditions may be associated with a moderate degree of degeneration of the posterior columns of the spinal cord, and consequently may present some mild symptoms of ataxia. The fully developed progressive type of the disease is, however, definitely syphilitic. As a general average of paresis, 81 per cent in the blood serum and 85 per cent in the spinal fluid, and in tabes 65 per cent in the blood serum, and 68 per cent in the spinal fluid give positive results. In these cases it is the progressive types which furnish the positive reactions, while the stationary cases those in which the syphilitic agents has become eradicated or quiescent are generally negative.

In cerebrospinal syphilis the results are rather conflicting, about 50 per cent giving positive reactions in the blood serum, and as has been reported, from none to 58 per cent in the spinal fluid. It has been considered as a point of diagnostic importance that relatively few cases of cerebrospinal syphilis give positive reactions in the spinal fluid, yet it can be shown that when relatively larger amounts of this fluid are used for the test, the positive reactions obtained closely follow the results in the blood serum, so that this distinction if relied on is misleading. Usually, however, cases of cerebrospinal syphilis give rather less frequent positive results than are found in tabes. Probably this is because many cases of cerebrospinal syphilis present only the results of the disease, and are not at the time of examination actively syphilitic processes. We cannot, I feel certain, by the results of the Wassermann reaction either on the spinal fluid or blood serum, differentiate between cerebrospinal syphilis, tabes and paresis. It does however, indicate those cases which are liable to be progressive, in which the syphilitic virus is still alive and which will be benefited by antisymphilitic treatment.

It may well be wondered why any syphilitic infection can remain dormant in a spinal cord or other tissue and only after many years begin to produce its effect. Tubercle, however, may do the same thing, and some modifications in the subject's condition may be responsible for the sudden active development of the infective agent. The lesions in tabes are particularly the results of a long continued toxic change degenerating the posterior column, a situation that may well be imagined considering the prolonged duration of a latent stage in many cases of syphilis.

Other nervous diseases, such as amyotrophic lateral sclerosis, dementia praecox, disseminated sclerosis, syringomyelia, alcoholic psychosis, cerebral tumors, epilepsy, etc., are not related to syphilis, if one may judge by the negative reactions which they almost invariably present.

In diseases of the cardiovascular system, many questions at issue have been decided by this reaction. Cases of aneurysm, for instance, where the relation to syphilis has long been advocated, give positive reactions in about 70 per cent of cases. It is also remarkable the frequency with which aortic incompetence is related to syphilis, as about 72 per cent of cases are positive. Aortic incompetence in the majority of cases is undoubtedly syphilitic in origin, and therefore different in its etiology from mitral valve diseases, in which the Wassermann reaction is generally negative. All other cardiovalvular lesions excepting aortic incompetence give only 24 per cent of positive reactions. Even this latter figure shows the high incidence of cardiac disease in syphilis. In relation to the etiology of cardiac arrhythmia the discovery of a syphilitic basis for this condition is by no means uncommon, as syphilis in all its stages is particularly liable to affect the auriculo-ventricular bundle and so damage the conduction system of the heart.

Syphilitic aortitis, a condition which can as a rule readily be distinguished pathologically from other varieties of arteriosclerosis, occurs in about 82 per cent of paretics, but in only 10 per cent in all syphilitics, and thus is as truly a parasymphilitic lesion as is tabes or paresis. It is the essential lesion which is the precursor of most cases of aortic aneurysm. Only very few aneurysms result from the ordinary forms of arteriosclerosis.

Of all cases presenting marked evidence of arteriosclerosis, only about 12 per cent give positive reactions, showing that this disease may be produced by many other factors even as common or more commonly than by syphilis, and also that aneurysm in nearly every case is of syphilitic origin.

When we find it reported that all cases of keratitis, exclusive of

suppurative cases, 81 per cent, iritis 38 per cent, retinitis and choroiditis 26 per cent, give positive reactions, the importance of this test in diseases of the eye is evident, particularly as an indication for therapeutic measures. Similarly it has shown that ozena is generally, but not always, of syphilitic origin.

Before any application of the serum test for syphilis is made, in relation to the diagnosis and treatment of the disease, the general biologic principles involved in the reaction must be thoroughly appreciated. It is essentially a laboratory method, and is only of value in the hands of trained serologists, as there are innumerable possibilities of faulty technique, which may materially modify the result. Too often this reaction is rendered worse than valueless by being done in the most imperfect way without all the possible sources of error being appreciated and controlled, and using the most inefficient and incorrectly standardized, often under-standardized reagents.

It is not the comparatively simple process it was originally conceived to be, supposedly depending on the union of a definite syphilitic virus and syphilitic antibodies. The first antigens used were derived from syphilitic tissues, yet it has been shown that certain fatty extracts of normal tissues are equally efficient. The growth of the *spirochaeta pallida* in the tissues seems to produce in the serum lypolytic substances which have the property of uniting with certain fats which are soluble in alcohol and other but not in acetone. Like all antigen antibody unions this binds a definite amount of complementor as it may be termed, gives a positive reaction. In practically any condition other than the growth of the *spirochaeta pallida* is there a similar development of these lypolytic substances in the serum. A positive reaction therefore indicates, so far as can be determined clinically and experimentally, an expression of spirochaete action on the tissues of the body and does not indicate the production of antispirochaete bodies in the serum. That immune bodies such as are formed in typhoid and tuberculosis are formed in syphilis, can also be shown by the use of antigens made from spirochaete cultures. Positive reactions obtained in this way are however, very limited in range as they occur particularly in the latent and tertiary stages and practically never in the primary or secondary stages. The cutaneous inoculation of Luetin which is an emulsion of spirochaetes gives very much the same results and is not then so reliable an indication of active syphilis as is the Wassermann reaction where fatty antigens are used.

Experience has proved the Wassermann reaction if efficiently

conducted to be a most reliable indication of syphilitic infection, and of active spirochaete growth in the body.

Only very few other diseases are associated with positive reactions. Cases of leprosy are credited with between 10 and 70 per cent of positive reactions. Noguchi found it positive in 72.2 per cent. My own experience is limited to three cases, all of which were negative. In scarlet fever, also, reports vary extensively from 1 to 50 per cent, Swift finding 5 per cent and Fua and Koch 12 per cent. In yaws and trypanosomiasis the Wassermann reaction is also described as frequently positive, so also in some occasional cases of anemia, tuberculosis, cancer, lymphadenoma, and leukemia. Since the discovery of the reaction, improvements in technique have greatly improved its specificity, and considerably fewer positive reactions are now obtained in other diseases than syphilis, so that for all practical purposes, in this location, the finding of a positive reaction indicates a diagnosis of syphilis.

The value of a negative report, although important, is not quite as definite. A positive reaction may occasionally be delayed until the second week of the secondary stage. The reaction may be temporarily negative when the activity of the syphilitic virus is depressed by treatment. The disease may be the result of syphilis, yet exist in a condition in which there is no spirochaete activity, or the disease is cured. Also the binding substance in the serum may be in such small amounts that the preliminary devitalization of the serum reduces them until they are insufficient to produce a positive reaction. Such weak reactions are commonly encountered in the late stages of treatment. It is stated that after the ingestion of alcohol a positive serum is apt to become negative. In several cases I have tried this but have not been successful in appreciably changing the reaction. Negative reaction may also be readily, and commonly are produced by imperfect technique.

As the greater certainty of the Wassermann reaction in its technique and specific relationship to syphilis has become more thoroughly established, treatment is now largely guided by the results of serum tests, a positive reaction being held as indicating the presence of active spirochaetes in the body. Efficient treatment can therefore be commenced much sooner, when the disease is more readily influenced. The longer the commencement of treatment is delayed the greater difficulty will be experienced in removing a positive reaction from the serum, and until this is done the patient is not thoroughly under the influence of treatment. In the primary stage, and to a somewhat less extent in the se-

condary stage, a positive reaction is usually easily removed and requires as a rule a relatively short course of treatment to make it remain permanently negative. In latent and tertiary syphilis however, where the spirochaetes become entrenched in the spleen, bone marrow and in inflammatory foci, the most extensive and prolonged treatment is generally necessary before the serum becomes negative and remains so permanently. It can be shown that even minute traces of mercury bichloride can destroy the binding substances in a syphilitic serum in vitro. It is therefore not to be wondered that even after short courses of mercury the number of positive reactions is considerably reduced. One negative result is then of little importance, if obtained in course of treatment. If treatment is stopped the activity of the spirochaetes recommences and a positive reaction again is apt to occur. Repeated negative reports, however, at intervals after the cessation of treatment, indicate the probability of a final cure. A serum should not be examined for the Wassermann reaction before one month after the conclusion of treatment, as negative results before this are of little importance. A negative reaction six months after the termination of the course of treatment would seem to indicate a cure. I have never seen a case remaining negative three months after treatment is stopped, again become positive. An interesting finding, and one which is sometimes of use in doubtful cases, is that after an injection of salvarsan in a recently treated syphilitic presenting a negative reaction, the serum may again become positive for a short time, one or two days, as if the drug temporarily stirred up the activity of the spirochaetes in the tissues.

The time after which treatment causes the reaction in the serum of a syphilitic case to become negative, varies with the severity of the case, the stage of the disease, and the amount of present and past treatment. Sometimes two or three doses of mercury may cause a temporary disappearance of the binding substances in the serum. In others very vigorous treatment has to be pursued before the reaction becomes negative. The object in the treatment of a syphilitic case should be to commence treatment as soon as the nature of the disease is determined, and as rapidly as possible to produce a negative reaction in the serum, and having accomplished this, treatment should be continued until a negative reaction is permanent for at least three months. In this way there will be the least possible chance of development of any serious after-results of syphilis such as aneurysm, aortic incompetence, tabes, paresis, keratitis, and the birth of syphilitic children.

Even if any such untoward results have occurred, there is now a considerable amount of evidence that their progressive character may be arrested. Such damage to the blood-vessels as occurs in aneurysm or to the nervous system in tabes and paresis is of course permanent, but if the progression of these diseases can be stopped, then a great advance has been marked in their treatment. In the case of tabes, the undamaged portion of the cord may assume a considerable proportion of the functions which have been impaired by the destruction of certain tracts. Thus reeducation exercises may largely improve the clinical condition of the subjects of this disease after its progressive character has been arrested. That some cases of late syphilitic disease present negative reactions it is also of importance to recognize, as it prevents the indiscriminate administration of anti-syphilitic treatment when the disease is already stationary and a healed process, and in which specific treatment would be of no avail or worse.

In relation to the treatment of those cases of paresis and tabes which present positive reactions and which therefore are actively syphilitic, it has been claimed that arsenic preparations such as salvarsan or neo-salvarsan are injurious to the nervous tissues. Particularly, it has been stated that the administration of these substances may be very injurious to the optic nerves. There does not seem however, to be any special liability to damage these nerve structures, and there should be no hesitation in pushing the treatment of these nervous cases as is done in any other syphilitic process. In tabes cases, an additional method of subjecting the spinal cord to the influence of salvarsan or neo-salvarsan has proved of very considerable value. The patient is injected intravenously with either of these remedies. One or two hours later his blood is again drawn off and 15 to 20 cc. of the serum is injected into the spinal canal after a similar amount of spinal fluid has been drawn off. In this way salvarsan can be diluted in the serum to a safe limit and applied directly to the spinal cord. Often this procedure is attended with very rapidly beneficial results in arresting the progress of the disease. In one tabes case which recently occurred in the Bell Hospital, severe, almost continuous rectal crises were abruptly stopped by one treatment of this sort.

The study of the Wassermann reaction in the last few years has shown that by the older methods of treatment administering mercury preparations internally even very thoroughly in only one case in four at the most, has the disease become eradicated. Although many cases of syphilis are cured spontaneously, yet day after day we see cases of tabes, paresis, aneurysm, etc., which pre-

sent identical histories of having had very extensive internal mercury treatment for one or two years. The method stands condemned by its eloquent results. The intestines rapidly acquire a high degree of tolerance to mercury salts and after a short time their administration is followed by only a very slight amount of absorption of the drug and practically its entire action is only exerted in the direction of weakening the patient.

Intramuscular injections of mercury, particularly the insoluble salts which have proven the most effective, the salicylate for example, are immensely superior to the internal administration of the drug. Even this procedure is very slow in its action, requiring many months as a rule before the serum reaction becomes permanently negative, and in many cases the positive reaction cannot be reduced at all.

Salvarsan and neosalvarsan if given in sufficient amounts, and controlled by the Wassermann reaction have proved efficient to cure the disease in the great majority of cases. The superiority of these drugs is well demonstrated by their ability to very rapidly remove positive serum reactions, even those which have completely resisted prolonged mercury administration. What takes months to accomplish by mercury treatment can be more easily obtained in a similar number of weeks by salvarsan.

Mercury combined with salvarsan is, however, more satisfactory than either alone.

As regards treatment by salvarsan, I shall only say, that one or two doses only rarely is capable of permanently removing a positive reaction. What has been in my experience the best method of administration is intravenously in relatively small doses, such as .3 grams repeated every week for about four injections. Sometimes it requires considerably more than this to get the serum negative. At the same time one grain of mercury salicylate is also being given intramuscularly. If the Wassermann reaction is negative at the end of this period, mercury injections are continued intermittently for six months. At the end of this time all treatment is discontinued for one month. If the Wassermann reaction is found positive the entire course of treatment must be repeated. If negative, as it generally is, particularly if treatment has been commenced early in the disease, three months more are allowed to elapse and if the serum still presents a negative reaction, experience has shown that the possibilities of the future development of syphilitic lesions are reduced to a minimum. No case of syphilis should really be pronounced cured without there having been a negative serum report six months after all treatment has been discontinued.

Neosalvarsan has the advantage over salvarsan in its ready solubility and its non-irritating character. It requires however, very much larger and more often repeated doses. Unlike salvarsan, it is absorbed readily in the tissues, about 75 per cent of a full dose, 9 grams, being absorbed within a week. Even at this rate however its action must be very inferior to the intravenous method, by which full doses can be administered two or three times a week for the first two weeks.

In conclusion, it may be repeated that the Wassermann reaction has been one of the most important factors in changing the treatment of syphilis from speculative uncertainty, to the present, earlier commenced, more rapidly effective, more certain, more definitely curative and more scientific methods.

—o—

ETIOLOGY OF ECLAMPSIA.

DR. L. V. SAMS, Topeka, Kansas.

Read before the Northeast Kansas Medical Society, February 6, 1913.

Feeling that the interest in this subject is general, I will endeavor to give a brief review of recent publications in reference particularly to its etiology. Probably not less than four hundred papers have been written in the last three years dealing with this dreaded complication of pregnancy. The result of all the work, assiduously pursued in this country and abroad by the best of scientific workers, must prove disappointing, though full of interest to the earnest seeker of modern medicine.

Eclampsia is yet a disease of theories, and probably nothing proves that statement more clearly than the fact that recently a French writer suggested seriously the possibility of a paternal origin of maternal puerperal eclampsia. In the light of the latest contributions, however, such a suggestion may contain a trace of justification, although never thought of by that French contributor. If eclampsia, as now claimed by some writers, is the expression of an anaphylactic condition, the paternal sperm portion of the developing embryo probably would represent the absorbed alien proteid sensitizing the pregnant women. Theories almost without number have been advanced to conclusively prove the etiology. In brief, I will name a few of them.

The renal theory—probably the oldest—has its supporters. Ahlfeld holds that there is no eclampsia without a preceding renal insufficiency. In primigravidae, it is usually due to mechanical and less commonly to toxic causes, while in the multigravidae,

almost without exception, it is due to chronic disease of the kidneys.

Relation between climate and eclampsia has often been referred to, and disclaimed by others. Roth maintains that unpleasant, warm wet weather increases the number, simply because such weather has a recognized bad influence on renal diseases.

Jacobson says that in dealing with eclampsia we have a uremia caused by a nephritis, and that pregnancy, labor or the puerperium are mere coincidents. He mentions incidentally that no eclamptic is free from some form of nephritis. In contradistinction, Beer has collected a number of typical cases of eclampsia with perfectly normal urine, and reports three autopsies showing perfectly normal kidneys. Beer concludes that the renal lesions, so commonly found, are the expression of a secondary impairment of these organs, but do not have a part in the actual causation of eclampsia.

Cova states that as eclampsia occurs in from five to eight primipara to one multipara, that a second attack is rare, and that the disease usually produces immunity.

Beathe made special investigation along this line and collected fifty-three cases of repeated eclampsia in the same patients and that the comparative rarity of second attacks is due to the fact that succeeding pregnancies are apt to end prematurely owing to the death of the foetus.

In the most recent literature, the placenta plays an important place.

Lichtenstein classes the theories assuming a placental origin of the eclampsia toxins into four groups: first, according to Vait, who was the first to base an eclampsia theory on Ehrlich's work on immunization, the disease is caused by the deportation of a large amount of fetal tissue, in form of detached villi or masses of syncytium into the maternal blood. Second, according to Ascoli the resulting syncytiolysis; third, according to Weichardt syncytiotoxins liberated by the lysins represent the responsible toxic substances, and fourth, Liepmann finally claims that the toxins are formed in the villi themselves. In Lichtenstein's belief the theories of Veit, Ascoli and Weichardt today must be considered exploded by the work of many other investigators. He, himself, undertook to control the experiments of Liepmann and finds them so faulty in many respects that they must be regarded as unconvincing. He deduces finally that all placental theories are untenable. There is another new placental theory, which, however, does not seem very plausible. Mirto finds that the relation in weight of the fetus to that of the placenta in eclampsia is con-

stantly less than in normals. He bases his theory on the fact that a relative placental insufficiency may allow the passage into maternal circulation of certain fetal waste products, which usually are neutralized by placental secretions.

Dients has extensively investigated the blood, urine and amniotic fluid of eclamptic, normal, pregnant and puerperal women and is led to the conclusion that there is an abnormal of fibrin ferments and fibrinogenous substances in the blood of eclamptics. He holds that the toxic substance, which during pregnancy produce hydrops and albuminuria, is fibrin ferment retained in abnormal quantities in the blood, after having been set free there as a result of physiological destruction of polynuclear leucocytes during pregnancy. The finding of thrombi in various organs in dead eclamptics would give weight to the theory.

It has been a long while since it was proven that thrombi intravenous injections of placental tissue emulsions injected into animals will cause death if not serious disease; thereby indicating that it is rich in toxic substances. Maithis, however, says that even if placental emulsion in great dilution is toxic, that autopsies show thrombi in large numbers, and is inclined to the theory of death from thrombi and not toxin.

The lactic acid theory of Zweifel has been discredited by many authors, as it has been conclusively shown that lactic acid is abnormally present in most cases of convulsions, whether eclamptic or not. Donath was unable to detect lactic acid in the spinal fluid of eclamptic patients, and also failed in animal experiments to produce convulsions by the injection of lactic acid into the blood. He says that the presence of lactic acid in the blood of eclamptics is due to a surplus suddenly formed in the muscles during convulsions. Mitchell with McCallam claims that tetany is due to calcium deficiency. In comparing tetany with eclampsia he states that in eclampsia the deficiency is more pronounced. He finds its expression in the decay of teeth, the possible development of an osteomalacia, in the not uncommon craving for chalk, slate pencils, etc. Probably the most recent theory advanced is that eclampsia is a phenomenon of anaphylaxis. Just a word in explanation of anaphylaxis. The introduction of a soluble alien, heterologous proteid parenterally, i. e., by some other route than the alimentary canal, renders the injected animal hypersensitive after a refractory period of incubation varying in different animals; but being approximately in from eight to ten days. If after this refractory period a second and even smaller dose of the same foreign proteid is injected (intramuscularly, intravenously or intraperi-

toneally), the hypersusceptible animals reacts promptly with symptoms of a grave character, often with immediate death due to asphyxiation. It is assumed that the first dose of the foreign proteid (antigen) leads to the gradual increase of specific antibodies already anormally present in the blood in small quantities. If, after the refractory stage, another dose of the proteid is introduced, the antibodies now present in large quantities produce a rapid disintegration of the injected proteid, probably into the same products as it would yield during intestinal digestion. While in the latter process, however, these products undergo further cleavage before being reabsorbed in the former they are liberated directly into the blood stream. These products are toxic and promptly lead to a condition known as anaphylactic shock.

Andusan and Rosenau have credit for first suggesting the possible relation of anaphylaxis to eclampsia. In 1908 they wrote, "the symptoms which cause puerperal eclampsia and the conditions under which it occurs suggest that anaphylaxis may explain some of the mystery of this state." It occurred to us that either the blood or proteid substances in solution from the fetus or placenta may first sensitize the mother. A subsequent introduction into the system of the mother of a similar substance may explain the convulsions and the symptoms which occur in a certain class of toxemias." Series of experiments with the guinea pigs has shown that the mother may be sensitized with the antolytic products of her own placenta. These findings naturally suggest that there may be a certain relation between some cases of puerperal eclampsia and the phenomena thus found in the guinea.

However, it is not to say at this time that all that holds good with experiments with the guinea pig can be relied upon in the human, as it has been proven that marked difference in the phenomena of anaphylaxis can be observed in animals of different species. Nevertheless, certain positive facts have been established which made it seem possible that certain symptoms of toxemia during pregnancy may be due to a hypersensitization developed during gestation. The anatomical basis for the parenteral introduction of proteid during pregnancy has been furnished by Schmoel and others, who established the fact of deportation of chorionic tissue into the maternal system as a normal occurrence.

The main difficulty was presented in the necessary proof that fetal tissues prove heterologous, i. e., foreign towards the mother. Histological and biological differences between fetal and maternal blood are well known. Wolff-Eisner reminds us of the fact that chorionic tissue, like every fetal tissue, contains a definite paternal

constituent. This makes the assumption of heterology more acceptable, especially in view of certain experiments proving that semen may prove toxic to the very individual from whom it is taken. Attention is also called to the fact that the symptoms of sperma resorption, e. g., in cases of sexual abstinence, like the symptoms of anaphylaxis, are chiefly due to vasomotor disturbances.

Thies injected the blood serum of feti into pregnant and non-pregnant rabbits, and found that definite clinical pathologic-histological symptoms closely resembling those of anaphylaxis are produced in pregnant rabbits after the first injection. These experiments would prove that a rabbit can be sensitized with fetal blood, and that the pregnant rabbit is in a condition of hypersensitization. It may be stated at this point that Fellander repeated these and other experiments, but was unsuccessful in his attempts to sensitize guinea pigs with either placental extract, fetal serum or milk. He was unable to render guinea pigs passively sensitized against amniotic fluid or placental extract by means of eclamptic blood serum; and concludes that he has utterly failed in confirming any of the experiments which apparently prove the relation of eclampsia to anaphylaxis. He emphasizes the following important facts. While anaphylaxis is characterized by a marked reduction of coagulability of the blood, an increased coagulability is generally acknowledged to exist during eclampsia. For the anaphylactic state, leucopenia; for eclampsia leucocytosis is the rule. In anaphylaxis the blood pressure is usually lowered; in eclampsia almost without exception, increased. At least in guinea pigs during anaphylaxis the temperature is markedly lowered, while in the serum disease of the human being, the temperature is always above normal. In the latter disease, albuminuria is rare, while it is the rule in eclampsia.

An unbiased critical review of all the available literature thus seems to force us to the very disappointing conclusion, already indicated in my introductory remarks, that some of the advocates of the anaphylactic theory undoubtedly are over enthusiastic, and that eclampsia still remains the "disease of theories."

—o—

DIAGNOSIS AND TREATMENT OF ECTOPIC GESTATION.

DR. J. C. McGEE, Leavenworth, Kansas.

Read before the Northeast Kansas Medical Society, October 24, 1912.

To say that a large number of cases of ectopic pregnancy pass

unrecognized will, I think, meet with your approval, but with our advancing knowledge and better training in diagnosis the number should be fewer.

The first case of ectopic gestation on record was reported by an Arabian physician in the eleventh century. Jacob Rufer is supposed to have operated on his wife for an extrauterine pregnancy in 1500. Lawson Tait and Sutton have given the subject extensive study and have reported a large number of cases.

In this paper we will not discuss the etiology and pathology of this condition but devote our attention to the diagnosis, both direct and differential.

The diagnosis of extra-uterine pregnancy is often made before rupture and the patient given the benefit of a safe operation because of the fact that hemorrhage has not as yet taken place.

The diagnostic signs of extra-uterine pregnancy are:

1. Cessation of menstruation.
2. Other signs of pregnancy as nausea, enlargement of the breasts, darkening of areola around the nipples.
3. Pain in the pelvis, presence of a sensitive tumor distinct from the uterine.
4. Sudden severe pain often following exertion.
5. Marked anemia or collapse.
6. Repeated attacks of pain and pelvic peritonitis.
7. Pain on defecation and urination.
8. Recurrence of irregular, more or less profuse menstruation, dark in color.
9. Discharge of decidual casts.

Diagnosis of Unruptured Cases.—The patient usually gives a history of having borne several children. There may or may not be a history of pelvic disease. There is a history of cessation of menstruation for one or two periods accompanied by the usual early signs of pregnancy. The patient complains of an uneasiness in either side of the pelvis and upon examination an ovoid tumor which is sensitive to the touch is felt. The uterus is enlarged and the cervix softer.

The first knowledge of the condition may be finding the patient in the state of collapse after a sudden sharp pain in the lower abdomen. The patient may be unconscious. A rapid pulse and sighing respiration indicate rupture and hemorrhage. Together with symptoms of rupture there is a hemorrhage from the uterus with discharge of decidua.

The symptoms may not be so marked. The progress may be insidious, if only a small rupture had occurred, and pregnancy may not be interrupted.

In some of the cases I have observed rupture followed some unusual exertion in others there was no such history.

Differential Diagnosis.—It is important to remember that tubal pregnancy may be bilateral and that uterine and tubal pregnancy may coexist. There is a case of twin tubal pregnancy and intrauterine pregnancy on record.

Tubal pregnancy may be repeated.

Tubal pregnancy and ovarian and parovarian tumors may coexist.

We will now consider briefly the condition from which we must distinguish tubal pregnancy. Some of them are quite easily differentiated, while others are not, but in a discussion of this kind it is essential for us to study them all.

Ectopic pregnancy must be differentiated from the following:

ECTOPIC PREGNANCY:

History varies from previous normal pregnancy.

Uterus firm.

Per rectum no thinned lower uterine segment.

Ballotment absent.

INTRAUTERINE PREGNANCY:

History normal.

Softer consistency.

Per rectum thinned lower uterine segment is felt.

Fluctuation and ballotment present.

As a last resort examination of the uterine cavity may be made then:

Scrapings show decidua minus chorion.

Scrapings show decidua plus chorion.

Absence of decidua does not exclude either extra or intra-uterine pregnancy.

SACTOSALPINX:

1. History of an infection as a recent abortion.

2. Consistency usually elastic at times fluctuating.

3. Usually tender on pressure.

4. Adhesions common.

5. Uterine end of tube firm and thickened.

RUPTURED TUBAL PREGNANCY:

Pain of short duration.

Pulse rate high.

Temperature at first sub-normal.

Septic symptoms usually absent.

Symptoms of internal hemorrhage.

ECTOPIC PREGNANCY:

Usually early signs of pregnancy.

One or more periods missed.

TUBAL PREGNANCY:

1. Usual history of pregnancy as amenorrhea, enlarged uterus, enlargement of breasts, increased darkness of area around the nipples, and morning sickness.

History of severe pain, collapse, discharge of blood and decidua.

2. Consistency usually very firm.

3. Rarely tender on pressure.

4. Not common.

5. Commonly normal unless interstitial tubal pregnancy.

RUPTURED PYOSALPINX:

Pain continues longer.

Pulse rate slightly increased.

Temperature rises steadily.

Septic symptoms present.

Absent.

UTERINE AND OVARIAN TUMORS:

Absent.

Usual menstrual history.

Urgent symptoms at onset.
Rapid development.
Not sharply circumscribed.
ECTOPIC PREGNANCY:

Previous history may exclude tumor.
Cul de sac usually full.
Tumor not smooth and tense.
ECTOPIC PREGNANCY:

Amenorrhea usually for not longer than a month or two.
Sound shows position of body relative to blood mass.
Mass not clearly outlined?
Hemorrhage from uterus dark and profuse.
ECTOPIC PREGNANCY:

History of early signs of pregnancy.
Sudden onset.
Temperature normal or subnormal.
Collapse.
Fever begins after appearance of mass.
Mass soft; becomes firmer.
ECTOPIC PREGNANCY:
History of early signs of pregnancy.
Sudden appearance.
Consistency soft; then firmer.
Not sharply outlined.
Late shrinkage in size.

Absent.
Slow development.
Usually well defined.
HEMORRHAGE INTO AN OVARIAN CYST:
Tumor pre-existing.
Cul de sac not usually full.
Tumor smooth and tense.
RETROVERTED OR RETRO-FLEXED UTERUS:
If uterus is gravid there is longer period of amenorrhea.
If not gravid fundus easily located.

Distinctly outlined.
Hemorrhage light in color; may be profuse.
PELVIC PERITONITIS AND CELLULITIS:
History of infection.
Onset slower.
Elevation of temperature.
Absence of shock.
Fever proceeds appearance.

Mass hard; often softens.
SUB-SEROUS MYOMA:
May be absent.
Slow in appearing.
Consistency firm.
Sharp in outline.
Usually increases in size except after menopause.

The treatment of extra-uterine pregnancy either before or after rupture is surgical but some years ago other procedures were resorted to. Simpson advised the evacuation of the liquor amnii resulting in the death of the fetus. Others advised the injection of morphine and strychnine, also the use of electricity.

The fetus was sometimes removed through vaginal incision but these procedures have been abandoned with the exception of the last mentioned method.

Each case will suggest the proper method of treatment depending of course whether it is seen before rupture, after rupture or during the secondary growth of the fetus.

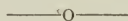
I believe that the abdominal route offers the easier and safer way of attacking these cases and it is up to the surgeon to decide as to whether the radical operation should be done on the tube or the conservation method followed. Personally I prefer to remove the tube and not try to leave a portion of it, for the reason that it is usually diseased throughout.

It is of advantage to give normal saline solution, either intravenously or under the skin, in cases where there is much shock. The incision should be carried quickly down to the peritoneum, the

source of the hemorrhage sought and controlled. Blood and clots should be as thoroughly removed as conditions will permit and a rubber tissue drain used. In advanced cases of extra-uterine pregnancy the treatment will depend on whether the fetus is living or dead and circulation in the placenta is active or stopped by thrombi.

All large vessels going to the sac should be ligated and the sac removed if possible. It is usually impossible to remove the placenta at once. If so, the cord should be cut short and gauze packed over the placental site. There is danger of secondary hemorrhage and infection.

If the child is viable operation should be done at once to prevent the onset of false labor.



Editor The Journal of the Kansas Medical Society:

My Dear Sir.—In an article appearing in the December number of the Journal under the heading, "A Plea for Uniformity in Drug Standards and for Uniform Requirements in Dispensing" by Professor L. E. Sayre, it appears to me that the article is so eminently misleading and that the title is used in such a manner to be misleading to the average physician, that after reading and re-reading, I felt impelled to enter a protest against such in behalf, not only of myself, but also in behalf of the great number of physicians all over the state who have the courage to dare, in spite of the protests of the retail druggists, to carry and dispense our own medicines.

The article is clothed in such a way that to many of us it appears very much as a wolf in sheep's clothing; and while the medical profession all over the state in general has a great respect for Professor Sayre, yet there are many who feel, that he is after all, lined up in the interests of the retail druggists; and the article in question lends itself in this direction with subtle influence.

I have yet to hear a single doctor who is not in favor of a uniform standard for drugs, and none can be found too pure or reliable for my patients; but I surely do protest when an effort is being made to prohibit me or any other physician from rightfully practicing our profession.

There are so many things could be said and so many reasons given in favor of dispensing that it would make my paper entirely too long, so I will confine myself to a rather short article.

It seems very strange that we should be in any way prohibited from dispensing our own medicine after we have carefully gone over the case in the quiet of our own office, and made a painstaking

diagnosis, and yet be necessitated to administer medicine to a critical case, far out in the country in the middle of the night, when often life is in the balance. Does it look just a little like a scheme to assist the retail drug man to the detriment of both patient and physician.

Again, a careful investigation shows, and experience and observation proves, from statements of physicians all over the state, that the average retail druggist prescribes and dispenses over the counter, and treats more cases of venereal disease than many physicians, and how often is a prescription refilled and refilled to the positive detriment of the patient, to the injury of the physician, but, to the profit of the retail druggist.

I believe in honesty in all things, and I say and say emphatically, that a law to prohibit us from practicing our own particular profession in all its details is unjust, selfish and unconstitutional.

Such a law has no more right to be enacted than a law to compel any tradesman to rent or hire his tools to do his work, nor one to compel a grocer to take his orders, and then have some other man supply the goods.

Should such a law come into effect it will not meet the exigencies in demand as the fountain head is the place to begin. There are a number of pharmaceutical and manufacturing houses whose preparations and manufactured products are absolutely reliable in every way, at least they are intended to be, and are thought to be by the ones making such articles, and these are subject to inspection and supervision by the Bureau of Chemistry of the Department of Agriculture, which makes it a National affair, and thus is striking at the root of the drug evil or drug adulteration far more effectively than can any law by state legislation, which has to do with the local pharmacies of the state.

Examples of such houses are John Wyeth and Bro., Fairchild Bro. & Foster; W. S. Merrill, Parke, Davis & Co., H. K. Mulford & Co., UpJohn etc., Merk, Squibb, Mallinckrodt, Powers and Weightman, etc., and many others. All of which furnish standard preparations and articles and from such the physician can supply himself with material suitable for his daily use in his chosen profession.

The Abbott Alkaloidal people are doing as much in the line of drug purity, accuracy of dosage and therapeutic efficiency, as is to be found anywhere in the country. The physician who has never investigated, and tried out thoroughly and scientifically their products and methods of treatment by active principal medication does not know exactly what accurate and scientific work they are doing.

All the representatives of the retail drug interests, including Professor Sayre, whose article appears in the December number of *The Journal*, use for their attacks upon the dispensing physician the assertion that the practitioners employ largely in his practice, "adulterated or substandardized medicines." This statement in one form or another has been used again and again in numerous drug journals and in many addresses given by special pleading enemies or opponents of the dispensing physician.

It has been asserted that the druggists stock of goods is subject to inspection by local authorities and therefore must be assumed to be good, while the dispensing doctors' stock of remedies not being subject to such inspection must be assumed to be bad.

Both these assumptions lend themselves to analysis:

First—As regards the inspection of the druggists' stock. It might be of interest to inquire how many inspections are made annually by drug inspectors in the state of Kansas.

Second—How many inspectors are employed?

Third—How many analysts are employed?

Fourth—The total number of drug stores inspected and the number of stores in the state.

Fifth—The total number of samples examined.

Sixth—The percentage of samples examined in the drug stores as compared with the number of remedies which are carried in stock.

I have no idea that one-tenth of the preparations and remedial agents, crude, manufactured or proprietary, carried in stock by any druggist in the state has been subjected to careful state inspection. In other words, while the moral effect of such inspection may be good, as a practical evidence of the value or valuelessness of any druggists supply of medicinal agents, such inspections are practically worthless.

In this connection, I might say that such inspection as have been made have shown that the druggists supply of medicinal agents are far from being up to the standard, are in a considerable percentage of cases below standard, and in some instances, worthless.

Let us cite the investigation of tincture of aconite as found in the drug stores of our state, out of some fifty preparations examined. (See Bulletin of State Board of Health August,

Here was a variation of about 1000 per cent in the strength, only one, I believe, being up to the standard of Squibbs tincture. These, some fifty preparations examined, ranged in strength all the way from less than two and a half per cent, ($2\frac{1}{2}\%$) to fifty

per cent, (50%) in strength of Squibbs tincture. These are facts as shown by Bulletin No. 8, August, 1910, under the direct supervision of Professor Sayre. In this investigation, they state, "Our investigations point to one thing definitely, namely, that tincture of aconite should be made from the drug itself and not by a dilution of the fluid extract." In looking over this list of something over fifty preparations examined, not a single sample was made from the drug itself, but the list shows: "from fluid extract," "unknown", "bought."

Seventh—It is assumed that the remedies used by dispensing physicians are not only inferior, but the inference is that they are uniformly inferior.

The foundation for this statement is not good.

Doubtless Professor Sayre, if he were asked to give the source of his information would refer to some investigation made by Professor Beal in Kansas, some eight or ten years ago. Little authoritative data upon this point has been prepared to my knowledge, since that time.

The much talked inferiority of the dispensing physicians' stock of remedies, rests, so far as I am able to learn, upon mere statements; mere hot-air, emanating from interested and unfriendly sources exclusively.

As a matter of fact, as Professor Sayre should know, the United States Government, through the Bureau of Chemistry of the United States Department of Agriculture, is investigating more closely and dealing more sharply, with offences as to purity and dose accuracy of the drugs used by dispensing (and other) physicians, than is any state in the Union.

This Bureau, has for the last two years, so I am informed, been collecting samples of drugs from every pharmaceutical and manufacturing house in the country doing an inter-state commerce business. These drugs have been rigidly examined, and deviations from the claims made upon their labels for purity and accuracy of drug content and exactness of weight has subjected a number of manufacturers to fine.

It is undoubtedly true that the pharmaceutical manufacturers are today exercising more care, thoroughness and skill in the preparation of the remedies which they offer to the physicians of the country than any wholesale or retail druggist doing business in the state of Kansas can possibly do.

As regards the quality of the drugs employed the Bureau of Chemistry is, today, safe-guarding the interests of the physician more rigorously than any state board of pharmacy has done in

the past as regards what the druggists offer for sale in the pharmacies of the state, or is ever likely to do.

In the light of these facts, the statement made by Mr. Boemer at the last meeting of the New York Pharmaceutical Association, (quoted by Professor Sayre), that physicians were purchasing heroin tablets, which contain no heroin, and morphine tablets which contain no morphine, and elixir of terpin hydrate without terpinhydrate, would need to be brought to the attention of the Bureau of Chemistry to secure the punishment of any individual making such tablets or preparations, and offering such for sale, unless such manufacture and sale both took place within the confines of a single state; and as regards that point, it seems hardly necessary, to add that there is probably not a single manufacturing pharmaceutical house in the country doing exclusively an intra-state business.

If there is such a one, the amount of business as compared with the general drug business of the country, must be very small indeed.

I also wish to express myself that Professor Sayre's reference to unworthy representation in the medical profession on page 486-7 of *The Journal* is manifestly unfair.

The inference is that they are representative of the type of the dispensing physicians of the state.

I should like to know if this is the inference which he intends to convey? If so, his position is of peculiar interest to the medical profession of the state, a great many of whom are dispensing physicians.

It is so nearly a self-evident truth, that no one is so much interested in the purity and efficiency of his drugs as the physician himself, (whose success or failure depends so largely upon the results obtained with them), that it would hardly seem necessary to discuss this point, and yet we are constantly being assured by our druggist friends, that we are too "ignorant", "too indifferent," "too anxious" to save money on our drug bills, to care whether the remedies which we buy are good or bad.

This certainly is not true of any self-respecting reputable physician. On the contrary, I believe that one of the principal factors which have led physicians to dispense their own remedies is the fact, that in their own local pharmacies they have been unable to secure the drugs which they require, and in the variety which their practice requires, and of the uniform high quality (which involves freshness of stock and freedom from deterioration) which they believe essential in the agents which they employ.

The dispensing of remedies has grown and is growing to a response to an undoubted professional and economic need. Any effort to stifle it should come only through proofs, satisfactory to physicians themselves, that self-dispensing of remedies is failing to satisfy them and their patients.

Such proof has never been submitted, on the contrary, we who dispense are bombarded with innuendoes, even from good men like Professor Sayre, with the implication that we are "pill peddlers" that we are "ignorant", that we dispense "just to make some money, that we dispense because we don't know how to write a good prescription.

Charges of this character are being repeated over and over, and they do not serve any good purpose, and they do not help to bring the pharmacists and physicians of the state of Kansas any closer in helpful association.

It has been bruited about that some one proposed to introduce a bill before the close of the present session of the legislature, to prevent physicians from dispensing their own medicines.

Professor Sayres' article, although clothed in courteous diction, seems to lead directly up to that point. He quotes a suggestion of Mr. Haines, that every dispenser of medicine should be a registered pharmacist, and he says that ninety per cent of the physicians applying for examination and registration have failed in their examinations.

Inference No. 1: Dispensing by physicians can be prevented by requiring them to take an examination before the State Board of Pharmacy.

The suggestion is also made that every physician should have his stock of drugs to meet the requirements of legal standards, and his stock should be open to inspection the same as any drug store.

Inference No. 2: The physicians drugs are to be subjected to examination by an unfriendly Board, consisting exclusively of pharmacists, whose peculiar interest lies in finding the physicians' stock of drugs inferior.

As a practitioner of medicine interested in the quality of the drugs which I employ, but as one who resents any outside interference on the part of those whose interests are not my interests or the interests of the people whom I serve, I shall protest continuously and persistently against self-interested supervision of my business by those who do not understand it and who wish, for selfish motives, to prevent me from practicing my profession in the way which I, and a large per centage of my colleagues, believe to be the best for my patients.

All publicity as to the value of the drugs used, I gladly welcome. I have not the slightest objection to their being inspected as often as anyone may wish; let them be inspected, analyzed and reported upon, by all means; but, if such inspection means, as appears to be the case, that we as physicians are subjected to persecution in the way of fines or other punishment, because that we prefer to supply our own medicines, then we feel that we have a right to enter protest against any such procedure.

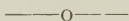
I appeal to the physicians of the state of Kansas to give this matter deserving consideration. It should be taken up and discussed in every medical society. Every physician of the state should understand the matter in its details, and view it from its different angles.

We should not sit up supinely and let a law of this kind be made without a vigorous and persistent protest.

I urge every physician of the state to keep in touch with his legislators and to object to the passage of any bill interfering in any way with the right of physicians to dispense their own remedies, until ample time has been given for a full understanding of the meaning of such a bill and for an opportunity for open discussion by physicians throughout the state.

I sincerely hope that our state organ, *The Journal*, will take this position and that the officers of the state society, as delegates representatives of the medical profession of the state of Kansas, will not countenance legislation of this character, until it has been subjected to most searching criticism and shown to be clean in character and satisfactory to the profession, and conducive to the welfare and to the best interests of the people whom we serve.

J. C. SHAW, A. M., M. D.



Diagnosis of Brain Abscess.—The diagnosis of brain abscess is to be made (like other intracranial conditions), by study of the signs and symptoms which result from its presence; in addition, a history of trauma, bronchectasis, empyema, etc., will prove helpful; while last, but by no means least, a study of the blood or the conventional changes due to existing suppuration should be made. If the abscess is within the cortex, or enveloped by the meninges, changes of the cerebrospinal fluid (i. e., lymphocytosis, increased serum-albumins, microorganisms, pus, etc.) may be anticipated. If the abscess be of sufficient size to alter the intracranial tension, a choked disk may be manifested; or if not quite sufficient to cause this phenomenon, a prechoked disk may be in evidence.—N. W. Sharpe in *The Journal of the Missouri State Medical Association*.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,**EDITOR.**

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

The protection of life, property and the conservation and promotion of Public Health are the fundamental duties of Government.—Ex-President Taft.

—O—

Are you making preparations to attend the annual meeting at Topeka, May 7-8. Certainly you must do your share to contribute to the learning of others, even if you have grown old in the service, and the meetings are a drag and a bore. If nature has endowed you with a master mind, for which there is no remedy, then you should disseminate some of the intelligence to the neophytes. If you cannot be repaid in kind, perhaps the hospitality for which the Topeka physicians are justly noted, will help to satiate your *blase* appetite. At any event, no matter what the reason is, come. Help make this meeting a success. It is going to be a success. There are some surprises engineered by the program and entertainment committee, which will open your eyes. The full program will appear in the April issue.

—O—

The annual meeting of the American Medical Association will be held at Minneapolis, June 17-20. The close proximity of the meeting should insure a large attendance from this section. Kan-

sas should especially send a large delegation. Besides the numerous advantages of the meeting, it can be made one of great pleasure, for many side trips of interest have been arranged. Perhaps the most interesting one will be trips through Yellowstone Park and Glacier Park. Attendance at the meeting and a trip through Yellowstone would make an ideal vacation.

The Annual Meeting of the State Society will be held at Topeka, May 7-8. REMEMBER THE DATE!

Dr. J. N. Scott of Kansas City, Mo., one of the pioneer workers with the X-ray, recently underwent the amputation of his left hand and lower third of arm. The necessity for the operation was due to X-ray burns received when protection from its ulterior effects were unknown or not provided against. Dr. Scott has our most heartfelt sympathy and best wishes. This misfortune but brings to mind one of the manifold dangers in the many by-paths physicians are compelled to travel, and emphasizes the fact that it is a profession calling many times for great personal sacrifices.

The newspapers have lately given considerable space to Dr. Freidman of Germany, who has "discovered" a "cure" for consumption. Whether or not he has made the discovery he claims to have made, remains to be seen, for certainly, he has not offered proof to verify it. It seems peculiar if he *has the goods* that he should exploit them in this fashion. He certainly must know that if he can demonstrate his cure successfully, he would not have to move from his doorstep to gather all the practice and incidentally the shekels, which apparntly he is quite willing to accept. This fact remains that seeing the *modus operandi* of his exploitation we must swallow the pabulum with many grains of salt.

Dr. Friedman we await the proof of your discovery with great doubt and forlorn hope.

The step which the American Medical Association is now taking in investigating the fee splitting evil in the medical profession has been undertaken none too soon. This practice is the greatest corrupting element in the profession today, those practicing it have in many instances become little better than the newspaper advertising fakers, with their brokers out in the field dragging up the business for them. As it now is, the physician in the rural district or small town, practicing this custom, uses the commercial method of shipping to the highest bidder. The surgeon

who is a true man of Christian character and with the highest type of surgical skill, who does not divide a fee is forced to compete with many an unscrupulous surgeon, who may not possess but very ordinary ability, but because he pays a liberal commission he gets the work, and what is still worse is doing a mutilating operation upon healthy tissues, which I believe is not such a rare occurrence, and also that the per cent of patients sent to a surgeon who does not split a fess is small, I regard the man who sends the patient to a surgeon and accepting a part of the fee as a commission, as more dishonorable than the surgeon, since the latter feels almost forced to do so. I have been much amused by hearing men who do the fee splitting, attempt to defend their course by explaining to our state society or other medical societies, that they always have it understood with the patient that they gave a part of the fee to the local physician. The shrewd fee-splitter does not try to explain it, as he knows there is too little truth in the above to be believed.

C. W. R.

INGRATITUDE.

As we go to press word has just reached us that Governor Hodges would not veto the bill which passed both houses and became a law, legalizing chiropractics. It provides that the chiropractors shall be recognized and permitted to register as such and even gives them a separate board of registration, consisting of 3 chiropractors, one preacher and one school teacher. It is hard to believe that Governor Hodges would permit a bill of this character to become a law. We can only say at this time that he has violated the trust imposed upon him by the medical profession. He knew this bill was an injustice of the worst type and will do immeasurable harm and then he refused to put upon it his stamp of disapproval. And that, after receiving the support of the medical profession at the recent election which made him Governor, he refused to listen or heed to the counsel of the physicians of the state. All of which shows the basest ingratitude and a dense ignorance of the needs of the people of the state. We are genuinely sorry—sorry that we have helped to put in such a man in the Governor's chair.

THE CHIROPRACTORS BOARD OF MEDICAL REGISTRATION AND EXAMINATION.

The physicians of Kansas who under the present college requirements, must attend school about six years in order to obtain a diploma, that will entitle them to practice medicine, must feel angered and injured by the passage of the Chiropractors Bill,

which will allow the same privileges to them without any requirements for preliminary or medical education.

The regular physician, who must be well equipped before he can practice medicine will not be injured in any way by this act, but the people who have need for the services of a physician are the ones who will suffer as they are not always competent to judge of the qualifications of a physician, and who naturally, may conclude that the State will only license persons who are competent to treat diseases, hence, that the chiropractors who obtain a diploma by paying so much for it in cash are as well qualified after obtaining a diploma and having the same registered as the regular physician who has devoted six years to the study in preparing himself before engaging in the practice of medicine.

I, myself, feel that this act is a direct insult to every honest physician in the State. No class of men and women do more for humanity than the educated physician. Much of the time of every physician is given to charity and in an effort to prevent disease, for which they receive no compensation, and have constantly labored to elevate the standard of medical education that the people may have the benefit of well educated and equipped physicians to look after them in sickness and to receive advice as to the prevention of disease.

Now comes a Democratic Legislature and passes a Bill that will invite every dishonest quack who is barred from the practice of medicine in any other State, to come to Kansas and buy a diploma and register under the chiropractors act. Governor Hodges should be ashamed of the part he has to take in allowing this Act to become a law. As an intelligent man (not playing politics), he must see the injustice of this bill, both to the physicians of the State and to the people who have need for the services of a physician and I now apologize to the physicians of Kansas for the small part I may have taken in securing his election and can only say, I made a mistake.

GEO. M. GRAY, M. D.

—o—

It is stated that the Kansas Legislature has decided to raise four thousand dollars to let the people of the State know what it has done. It is surmised that it will require a vastly greater sum than this to induce the reputable medical profession and their friends to forget some of the things that were done.

—o—

Governor Hodges could not have been elected Governor of Kansas without the solid support of the reputable medical profession of the State and it was upon assurances that the people would

be protected against vicious medical legislation, even to the extent of using his veto power, that he was given this support.

—o—

A DISTINCTION WITHOUT A DIFFERENCE

If Mr. Capper had been elected Governor of Kansas, the physicians no doubt, would have received what they expected, if not what they wanted. but as it is, they neither received what they expected nor what they wanted.

—o—

It was impossible to get a copy of the chiropractor bill, as passed in time for publication in this issue. It will, however, appear in the April issue, with a *resume* of all medical legislation enacted at the last session of the legislature.

—o—

THE TOPEKA MEETING, MAY 7 and 8.

The Shawnee County Society has a Committee which is actively at work arranging to entertain the largest and best meeting the State Society has ever held.

The meetings will be held in Representative Hall. The adjacent rooms and corridors will also be available, affording ample quarters for exhibitors.

One of the evenings will be spent at the State Hospital for the Insane, where a banquet will be served and the members will be entertained and instructed by clinics, demonstrations and papers by the physicians in charge, and enabled to see the splendid new equipment and up-to-the-minute plant for the treatment of the insane. The local committee and the profession at-large are very fortunate in having this splendid feature in prospect, and are under obligations to the authorities for the privilege.

The other evening of the meeting will be devoted to an entertainment for eyes and ears. The full details of this entertainment have not been worked out yet, and are not to be disclosed in advance, anyway. But the members may rest assured that it will be worth while, and something "different."

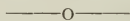
It is desired that a good line of exhibits shall be on hand. Prospective exhibitors should address Dr. W. E. McVey, Topeka, Kansas, who has this matter in charge. Dr. O. P. Davis, Topeka, is Chairman of the General Committee.

—o—

EDITORIAL CLIPPINGS.

Senate Declines to Consider Owen Bill.—The United States Senate recently, by a tie vote, refused to take up the consideration of the Owen Bill. This does not finally dispose of the bill as it

still retains its place on the Senate calendar and can be called up at any time and considered by a majority vote of those Senators present. As it is realized by those friendly to public health legislation that there is a little chance of the bill passing the House at the present session, the tie vote on the question of its consideration can justly be regarded with satisfaction by the friends of a broader national health organization. It is generally understood that Senator Owen will introduce a bill at the next session of Congress, if the present bill does not pass, but it is highly probable that such a bill will be redrafted and considerable modified. If this is the case, says *The Journal of the American Medical Association*, it is to be hoped that Senator Owen will go back to the original plan and draft a bill calling for a Department of Health, with a secretary in the cabinet. The growing realization of the importance of this subject and the increasing support for it show the educational value of the agitation which has extended over the last three years. The opposition has reached its high-water mark, and the false statements which were so widely circulated regarding the object of the measure and the purposes of its advocates have reacted. The Owen bills have made people think. If they will only think hard enough and long enough to realize the great importance of health conservation, the eventual, inevitable result will be the establishment of a national Department of Health. Nothing short of this should be the aim of those who appreciate the present public health conditions and the needs of the future.



The Cost of Destroying Life—According to Mr. E. E. Rittenhouse, conservation commissioner of the Equitable Life Assurance Society, \$1,500,000,000 is a low estimate of the annual economic loss from preventable deaths in the United States. The experience of Colonel Gorgas and his sanitary corps in the Panama Canal Zone is a convincing demonstration that good health is a purchasable commodity and that sickness can be insured against and prevented if the public is willing to pay enough for safeguards. The cost of accomplishing the wonderful saving of lives on the Isthmus is estimated at about \$2.43 per person annually. In contrast with such figures, which compare favorably with familiar per capita expenditures for fire and police protection and the conservation of material property, are the data relating to the cost of the actual destruction of mankind. According to President Jordon of Stanford University it now costs on the average about \$15,000 to kill a man in modern war, and in the Boer War this expense ran up to nearly \$40,000. When it is recalled that in a time of peace

we spend nearly a million dollars a day in our own country on matters concerned with past or future wars, it is comforting to know that the saving of human life is far cheaper than its destruction. Nations can afford to do their duty in preparing against a foe like the plague, the danger of which is always present and more ominous than war, quite as well as they can raise funds for defense against unlikely or avoidable human combats. Civilized nations show a lack of perspective, to say the least, says The Journal of the American Medical Association, when they continue to destroy life at high cost and fail to save it at a low cost when a combination of knowledge with a little national energy and international cooperation will lead the way to humane economies.

—o—

SOCIETY NOTES.

2nd District, C. C. Goddard, councillor, Leavenworth:

The Wyandotte County Medical Society held meetings the following dates: February 4th, program:

Report of a Case of Pulmonary Calculus, the Result of Trauma, Dr. J. E. Sawtell.

"Wassermann Reaction in Relation to the Diagnosis and Treatment of Syphilis." Dr. L. S. Milne, Professor of Medicine, Kansas University.

Discussion, Opened by Dr. C. C. Nesselrode.

February 18th:

Laboratory Examinations and Their Value, Dr. W. T. McDougal.

Report of Cases, Dr. G. M. Gray.

March 4th:

Phobias, Dr. C. C. Goddard.

Cardiac Arrhythmias, Dr. P. T. Bohan.

—o—

The annual meeting of the Douglas County Medical Society occurred on Tuesday, January 14.

Besides the local members present, Dr. Lee of Eudora was in attendance.

Officers elected for this year are:

President, Dr. S. T. Gillispie; vice-president, Dr. Edw. Bumgardner; secretary, Dr. H. L. Chambers; Treasurer, Dr. E. Smith.

—o—

4th District, W. E. McVey, councillor, Topeka:

At a recent meeting of the Riley County Medical Society, Dr. Robt. Leith was elected president and Dr. Thomas R. Cave, secretary, both of Manhattan.

5th District, W. E. Currie, councillor, Sterling:

Program of the Harvey County Medical Society for March:
MARCH—"EYE, EAR, NOSE AND THROAT."

"Nasal Stenosis", Dr. J. R. Scott.

"The Tonsil as a Source of Infection", Dr. R. S. Haury.

"Glaucoma", Dr. G. A. MacElree.

"Basic Principles of Refraction", Dr. M. L. White.

Review of Recent Literature or Report of Case, Dr. G. D. Bennett.

F. L. ABBEY, Sec'y.

—o—

The Butler County Medical Society met at El Dorado, February 20th. The following program was given:

Paper—Dr. A. H. Nossaman, Whitewater.

Talk by President, Dr. F. A. Garvin, Augusta, "Our Year as President."

Paper—Dr. D. B. Craig, Rosalia.

Secretary's Annual Report—Dr. J. R. McCluggage, Augusta.
J. R. McCLUGGAGE, Sey.

—o—

Reno County Society expects to entertain the societies of the seventh district sometime in April.

—o—

6th District, Arch D. Jones, councillor, Wichita:

At the regular meeting of the Kingman County Medical Society, which was held the first of the year, the old officers were re-elected:

Dr. A. C. Johnson, president; Dr. H. E. Hoskins, vice-president; Dr. J. McHaines, secretary; Dr. C. H. Longnecker, treasurer.

—o—

At the annual meeting of the Cowley County Medical Society held recently at Arkansas City, the following officers were elected: President, Dr. Charles Dunning; Arkansas City; secretary, Dr. C. T. Ralls, Winfield.

—o—

The 25th semi-annual meeting of the medical Society of the Missouri Valley will be held at the Coates House, Kansas City, Missouri, Thursday and Friday, March 20-21.

A series of interesting symposia has being arranged upon the following topics: Cancer, Rheumatism, The Colon and Genital Tuberculosis in the Female.

Among the distinguished men who are expected to discuss these and other topics, may be mentioned Surgeon-General Rupert

Blue; Dr. Joseph Colt Bloodgood, (Johns Hopkins); Dr. Robert T. Morris, New York; Dr. Stewart R. Roberts, Atlanta, (on Pellagra); Dr. Franklin H. Martin, Chicago; Dr. E. M. Hummel, New Orleans; Dr. C. Graham, Rochester; Dr. Carl E. Black, Jacksonville; Drs. W. T. Wootton and E. H. Martin, Hot Springs; Dr. A. L. Blesh, Oklahoma City, and others.

Members should make early room reservations at the Coates House, where the sessions will be held. A dinner will be served at 6;30 o'clock, Thursday evening, at the Coates, when members will be the guests of the Jackson County and Wyandotte County Medical Societies.

—o—

The annual meeting of the Northeast Kansas Medical Society was held in Kansas City, February 6th, under the presidency of Dr. Hugh Wilkinson. The attendance was not as large as at some of the previous meetings, but the program was of exceptional interest and created a lively discussion. The society was entertained with a dinner at the Grund Hotel by the Wyandotte County Medical Society. The following program was given:

Kidney Stones—Diagnosis; Treatment. C. J. McGee, Leavenworth..

Etiology of Eclampsia. L. V. Sams, Topeka.

Sinusitis, C. L. Zugg, Kansas City.

Exophthalmic Goitre, S. S. Glasscock, Kansas City.

A medical clinic was held by Dr. P. T. Bohan of Kansas City, Missouri, which was highly instructive and entertaining. The society will hold its October meeting at Leavenworth.

The following officers were elected:

President, L. V. Sams, Topeka; vice-president, J. W. Risdon, Leavenworth, secretary-treasurer, C. C. Goddard, Leavenworth, re-elected.

—o—

NEWS NOTES

Dr. Hugh Wilkinson of Kansas City, Kansas, announces the removal of his office from the Husted Building to the Grossman Building 642 Minnesota Avenue.

—o—

Dr. R. A. Roberts, J. L. B. Eager and James W. May of Kansas City, Kansas, announce the removal of their office to the Portsmouth Building, 6th and Minnesota Avenue.

—o—

The Trustees of National University of Arts and Sciences

of St. Louis, announce that a contract was signed on February 21, 1913, for the building of \$5,000 worth of apparatus for use in the physiology laboratory of the medical department (American Medical College) of the University. Dr. Bernard Blass, formerly of New York City, has been elected professor and head of the department of physiology, and will assume this position with the opening of the session of 1913-1914.

—o—

Examination of Drinking-Water on Trains.—As the result of an examination of water supplied to the public for drinking purposes by the railroads passing through Kansas, which disclosed that a considerable proportion of the water supplied was unsuitable for drinking purposes on account of pollution by icing, the board has ordered that on and after July 1, 1913, no railroad company and no officer or employee of railroad companies or any other person shall cause or allow any ice to be placed in or come in contact with any water which is served for drinking purposes on railroad trains or any passenger stations, and furthermore, that all drinking-water receptacles and coolers in passenger trains be thoroughly cleansed by said railroad companies and persons in charge of the cars containing the said water receptacles and coolers at all terminal stations or whenever or wherever such cars are cleansed.

—o—

At a recent meeting of the Cowley County Medical Society, a resolution of thanks was adopted to newspapers which omit the names of physicians in attendance on patients, whose cases are reported in newspapers.

—o—

There are only four states in the Union having no vital statistics law, viz., South Carolina, North Carolina, Georgia and Arkansas:

—o—

Dr. H. L. Aldrich of Caney, president of the State Board of Health has been elected coroner of Montgomery county.

—o—

Dr. E. A. Bodenhamer and wife of Wichita, returned after an eight months trip in the mountains of Colorado and New Mexico.

—o—

Dr. F. A. Garvin, Augusta, has been appointed health officer of Butler County.

—o—

Dr. John M. Schrant, formerly of Dighton, has returned from Europe and will be located in Hutchinson.

Dr. C. E. Hunt, Eldorado, for forty-two years in the practice of medicine, has retired to take up his new duties of probate judge of Butler County.

Dr. C. M. Hensley, Topeka, has been re-elected health officer of Shawnee County.

Dr. Marion Trueheart is attending the Mayo Clinics at Rochester.

CASE REPORTS.

A Case of Severe Burn of the Eye from the Contents of a Fluid Core Golf Ball.—The following case is reported on account of its unusual history, and to call more forcibly to the attention of the profession, the danger which lurks in a commonly used and supposedly innocuous variety of golf balls.

Miss W., aged 19, a resident of South Chicago, was brought to my office on October 5, on account of a severe burn of the right eye. She was accompanied by her fiancé, a young man of about 20 years, and his mother. The following history was given: Three weeks before, the young man was removing the cover of a golf ball. His fiancé was leaning over his shoulder when suddenly a stream of so-called "acid" squirted up from the core of the ball and struck her directly in the eye. She suffered intense pain in the eye and the skin surrounding the eye was burned in one direction for a distance of one or two inches. She immediately consulted a local oculist, under whose care she had been since the accident.

Examination demonstrated a deep opacity of the cornea in almost its entire area. In addition there was a cicatrized conjunctival area extending from the limbus for a distance of almost an inch to the inferior nasal aspect, at least one-quarter of an inch wide. The remaining bulbar conjunctiva was swollen and red. Vision was reduced to mere perception of light. Tension was minus. Enucleation of the eye was advised.

This is the first case of a burn of the eye by the contents of a fluid core golf ball that has come under my observation. Casey Wood, in the October issue of the Ophthalmic Record, reports a case of corneal burn sufficient to produce sloughing of that structure from this cause, and mentions at least two other instances of which he has heard.

The details of the case just cited and the histories of the cases

instanced by Dr. Wood should suggest to us as physicians the obligation we owe the public to warn them of the dangers of the fluid core ball when opened. I have repeatedly seen boys in the locality where I live removing the covers of old balls. Warning to the parents of inquisitively inclined children and timely admonition to curious adults will assist in preventing some serious burns of the eye and may perhaps be the means of saving the vision of some of these persons.—W. O. Nance, M. D., *Journal of Ophthalmology and Oto-Laryngology*, November, 1912.

—o—

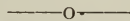
REVIEWS.

Formaldehyd Dermatitis.—W. E. Morgan, Chicago(*Journal A. M. A.*, February 22), calls attention to dermatitis caused by formaldehyd, especially in that used in denatured alcohol, which he thinks is being rather carelessly used by physicians and surgeons. He gives his own experience and says he has found the same susceptibility amongst his professional associates. To those thus affected he thinks the following measures can be recommended: "1. Avoid formaldehyd as you would a pestilence. 2. Wash the hands or affected parts not more than once a day with luke-warm water and a vegetable-oil soap, such as Castile. Avoid green soap made with a fish oil or any animal-oil soap. At other times use olive oil or cotton-seed oil for cleansing purposes. I have found that a little phenol (carbolic acid) added to the oil (10 minims to the ounce) keeps it free from becoming rancid and adds to its soothing qualities. 3. Apply to the affected parts two or three times daily an ointment made up of zinc oxid, 1 part, starch, 2 parts and petrolatum, 8 parts. During the vesicular and acute stages this should be applied without friction, but after the epithelium becomes dry and the derma somewhat thickened and scaly the ointment can be rubbed in and the zinc reduced somewhat. 4. Avoid all powders except sterilized starch, and then during the vesicular stage only. 5. Rubber gloves cannot be worn for more than from three to five minutes without producing marked irritation by reason of the confined perspiration. 6. Wear a cotton protecting sleeve or glove, or both, night and day until thoroughly healed. Silk or woollen goods cannot be allowed to touch or rub the affected parts without producing irritation."

—o—

Arteriosclerosis.—T. D. Coleman, Augusta, Ga. (*Journal A. M. A.*, November 30), says that arteriosclerosis is a penalty of our

present civilization, and its increasing frequency makes anything leading to its better comprehension desirable. Tissue nutrition in the body cannot be maintained without vascular tension, and when the vital activity of the endothelium is injured through long-continued strain, toxins or irritants, connective-tissue changes occur and arteriosclerosis develops. Why sclerosis develops more in some parts of the body, such as the brain and kidneys, than in others, is a puzzling question, though it may be claimed that these organs are more constantly active and liable to overstrain. Age is a constant cause, but no fixed period can be named for its appearance. The high pressure of modern life, with its stress and strain; the acute infections and intoxications; syphilis more frequently than supposed; poisons, intemperance of all kinds, are to be counted as causal factors. The effects of arteriosclerosis are disturbance of functions, the symptoms varying with the part affected. The first symptom may be apoplexy from rupture of a vessel in the brain, Sclerosis of the splanchnic arteries may cause attacks of abdominal pains, and it must be borne in mind that sclerosed arteries may exist without any signs in the palpable vessels. After it is well established, no return to normal may be expected. While blood-pressure tests are valuable and should be more generally used, they are still subject to error and should not entirely supplant the trained examining finger. Prevention of the condition is the best treatment; excesses of all kinds, worry, overwork and the strenuous life are to be shunned. Exercise should be adjusted to the needs, and where active exercise cannot be taken, properly directed massage may be a valuable aid. Baths, properly administered, are of distinct value, and the physical and mental activities must be carefully directed according to the needs of the case. Of course, diet should be directed; most persons eat too much and nearly all too fast. Individual peculiarities should be studied, and in all cases alcohol, tobacco, tea, coffee and other stimulants should be restricted in their use and doubtless forbidden in many cases. Coleman would be willing to risk the use of mercury in syphilitic cases, and says nitroglycerin can be safely used to advantage, but the less transient action of some of the nitrates makes them often preferable.



MISCELLANEOUS

CUT THIS OUT AND SEND TO SOME FELLOW PHYSICIAN NOT
A MEMBER OF HIS COUNTY MEDICAL SOCIETY.

Why you should join your county medical society:

1. Because it is a post-graduate school at home from which

you derive pleasure and increase your practical and scientific medical knowledge from the papers read, the discussions and clinical reports, making you a better and more successful practitioner.

2. Because it is the best means to promote friendships, mutual respect and pleasant social relations in your professional life.

3. Because it is the best means of avoiding envy, jealousy, local animosity and internal dissensions, which have always discredited our profession, and if you will permit them, will seriously damage your professional career.

4. Because it will help you to improve your financial condition by aiding you to better your business methods in your work.

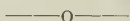
5. Because it tends to promote unity by which the profession gains in influence and commands a higher respect from the community.

6. Because the County Medical Society makes it possible to unite the profession into a compact organization to its material advantage and that of each of its members.

7. Because it will enable you to progress in your medical career and become a member of the State and National Medical Associations.

8. Because you owe all this to yourself and to your professional co-workers.

Therefore: Join your County Medical Society. "In union there is strength."—From Colorado Medicine.



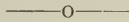
Getting Together in Kansas—An Example to Emulate.—To the Editor.—At the spring meeting of the medical society of a certain county in southwest Kansas, suggestion was made that one of the members of the society should be a candidate for the legislature, in order that the interests of physicians might be safeguarded by representatives from among the profession. This was determined because the interests of physicians were menaced by the last legislature and were also seriously threatened through the activities of the chiropractors and the League for Medical Freedom in the legislature which was to be chosen and is now in session.

After considerable discussion, it was decided that Dr. R. T. Nichols of Liberal (the county seat) should be the person to make the race. Dr. Nichols' popularity among the people had been attested by the fact of his election as mayor, and he had shown marked executive ability as well as much forcefulness of character in the conduct of the city's business.

Notwithstanding that the physician-candidate was a Democrat, while most of the members of the society were Republicans (Seward County in strongly Republican), they stood together "as one man" and succeeded in electing him. But the story does not end here. The doctors agreed not only that they would work for his election, which they did most heartily, but also, that they would turn back all of his patients on his return from the legislature and pay him a per diem bonus as well while he was in attendance at the capital.

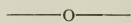
Dr. Nichols made his maiden speech the other day in the House, defeating the schemes of the enemies of the Kansas Food and Drugs Law by causing the untimely death of House Bill 76. This bill called for the reorganization of the State Board of Health, replacing the majority of the physicians on the board with laymen who are interested in the manufacture and sale of food and drugs. Incidentally, it might be remarked that the present Democratic governor (who won his election by a majority of 26 votes) was elected by the physicians of Kansas, 85 per cent of whom voted for him as against the Republican candidate—the publisher of the Topeka Capital and a large number of other publications which carry nostrum advertisements. Dr. Nichols is ably assisted by two other physicians, one of whom ran on a platform of public health education, disregarding the platform of his own political party.

Is it not about time that the physicians of the country should emulate the example set by the Seward County Medical Society, and "get together"?—S. J. Crumbine, M. D., Topeka, Kansas.—From Journal A. M. A.



Moving Pictures and The Eye.—I believe that moving pictures, if favorably presented, under the most favorable conditions, are a more or less severe test of distant vision and endurance on the normal eye, depending, of course, on the length of time the pictures are viewed. The vast majority of persons with normal eyes can endure four sittings of thirty minutes each per week, with but little or no temporary unpleasant symptoms and no permanent ill effects. The large proportion of those who complain of unpleasant symptoms under this time from moving pictures under the most favorable conditions have some error of refraction not properly corrected, improper muscle imbalance, or defect of sight, or constitutional condition lowering eye endurance. The symptoms produced are essentially those of asthenopia and their sequelae. Moving pictures, however, under unfavorable circumstances,

poorly developed, scratched or defective films, inferior cameras, objectionable screens, irregular and poorly-focused projection, too great or too slight illumination, etc., etc., even in moderation, will produce asthenopic symptoms in any pair of eyes, normal or abnormal. In those who suffer premature or severe asthenopic symptoms from moving pictures under the most favorable circumstances and in moderation, relief lies in the correction of any refraction error, and the benefits that medical science can afford, on the one hand, and less or no moving pictures on the other.—Bahn, N. O. Medical and Surgical Journal.



The Physicians' Decalogue.—I. Do not waste your time. Do something every moment.

II. Try to produce a good impression. Be well-groomed. Learn to talk well. Be a man among men.

III. Exercise your profession as a courteous gentleman, but be the man of business as far as necessary, just as much to give what you owe as to ask for what is due you in equity.

IV. Buy books. Subscribe to and collaborate with journals. Belong to societies and make your voice heard there.

V. Equip yourself with all that can materially increase your powers of diagnosis and therapeutics.

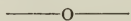
VI. Do not be ashamed to consult others. Give them of your knowledge, and take from them the least thing that may have any value for you.

VII. Be a real and not a make-believe investigator. Do not accept anything too confidently, but do not refuse anything because it is condemned.

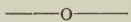
VIII. Let each case be for you a real subject of research, and leave in the darkness not a single fact that you are able to bring into the light.

IX. Avoid charlatanism as you would poison, but go back to the origin of its power, so that you may add it to your own equipment.

X. Wear no man's collar. Let your only masters be truth, honor and humanity.—Gazette Medicale de Paris.



For Sale.—Buick Auto, 1910, fine condition. Physicians' case record desk used but little. Very cheap.—Dr. C. J. McGee, Leavenworth, Kansas.



A story has it that once upon time a man called at the home of a physician in a small country town and asked him how much

he would charge to go to a point five miles in the country. On receiving the reply that the fee would be \$2.50, he told the physician all right, but to be in a hurry. The physician hastily dressed, hitched his horse and, taking the man in the buggy, drove in a lope the entire five miles. On arriving at their destination the man paid the physician the \$2.50, informing him that no one was sick and that the liveryman would have charged \$5 and would not have made such good time. The truth of the point of the story is driven home when we remember that we will drive across town and administer to the sick cheaper than a taxicab company would send a car with a \$7 a week chauffeur.—J. C. Ayres in Memphis Medical Journal.

—o—

Correction.—In an article on Artificial Infant Feeding by Dr. J. T. Scott, February issue: In the percentage table at the top of page 50, heading of first column should read "Fat" instead of Gastric Capacity.

—o—

There is But a Single Layer of Epithelium Between Us and Death.—I do not know whether you have thought of the importance of a single layer of epithelium to the human being. but the single layer of epithelium which lines the alimentary tract and the tubular glands is all that intervenes between the bacterial contents of the intestine and the venous and lymphatic circulation. As long as that single layer of epithelium is intact you are safe, but as soon as that single layer of epithelium is destroyed then a bacterial invasion of the veins and lymphatics begins and a dangerous condition supervenes.—C. B. Lockwood in Clinical Journal.

—o—

CLINICAL NOTES

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL OF SURGERY.

Blood pressure observations every few minutes are essential to the safe conduct of intracranial operations.

Before terminating a mastoid operation scrape clean the exposed bone surface. The wound will granulate more quickly.

A "positive" blood culture in a case of otitic or mastoid disease is pathognomonic of sinus involvement and an absolute indication to tie off the internal jugular vein.

Repeated aspiration of an ear discharge, the syringe tip or

totoscope snugly fitting the external canal, greatly accelerates the cure of an otitis media.

Chronic suppuration in the middle ear may be entirely due to an adhesion near the floor of the tympanum and the internal wall forming a pocket in which pus may lodge.

The healing of a mastoid wound is often accelerated by lengthening the intervals between dressings, allowing Nature to do her part in repair with minimal disturbance.

Persistence of suppuration after incision of a furuncle or abscess of the auditory canal or auricle indicates the development of a localized chondritis.

When operating upon a carcinoma of the stomach be sure to suture the layers of the abdominal wall with silk or linen. In these cases healing is very slow and the wound may burst open if absorbable sutures are used.

Circumscribed tenderness is especially significant of the location of a foreign body. Making allowance for the tenderness due to infection, when this is present, a point of persistent maximum tenderness is fairly diagnostic of the location of the body beneath that point. By pressure, with the finger tip or a slender instrument, on one spot after another in the suspected region, one may elicit only a single point of tender or a point of maximal, and several adjacent points of lesser tenderness. The single or maximal point indicates usually the location of the most superficial part of the foreign body, especially if it be a needle or sharp splinter of glass, wood, etc., the points of lesser tenderness map out, in a rough way, the general direction of the body.

Congenital absence of the appendix is exceedingly rare. Don't pronounce the appendix "absent" without searching behind the caput coli and without splitting the cecal serosa downward from the ileo-cecal junction—the appendix may be completely subserous, even though no thickening is felt. Moreover, the appendix is occasionally intussuscepted into the cecum. Of course, the organ may have been previously removed through some unusual incision, e. g., inguinal or femoral herniotomy.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, APRIL, 1913.

No. 4

CONSERVATION OF THE ETHMOID.

JOSEPH E. SAWTELL, M. D., Kansas City, Kansas.

Read before the Southeast Kansas Medical Society, Sept. 25, 1912.

Conservation of functioning organs of the body should apply no where with greater emphasis than to those within the nasal cavity on account of their important physiological functions.

In treating this subject it is not my intention to criticize in any measure the radical procedure that is often essential to obtain perfect relief, but rather to classify some of the pathological conditions and to advocate less radical measures in certain cases where as good results can be obtained without serious impairment of the physiological functions.

When Dr. Ballenger first read his article on Complete Exenteration of the Ethmoidal Labyrinth, and presented his instrument for performing this operation, it was denounced by some as bloody, brutal and unnecessary, but in the light of our present experiences when this operation is applied to the class of cases for which it was originally intended, it is the only procedure from which we may expect satisfactory results. When, however, the complete operation is performed without regard to varying pathological conditions then the above denunciation is, in a measure, justifiable.

A brief review of some of the predisposing causes of ethmoidal disease will give us a better understanding of some of the pathological conditions under consideration.

Some deformity of the nasal septum is without doubt the most frequent predisposing factor to ethmoid disease. In the first place the deformity may interfere with drainage and ventilation of the cells. In the second place the deformity may be such as to focus

the ingoing current of air upon the ethmoidal region and on account of the varying climatic conditions this may set up an ethmoiditis, the same as in the first instance. The latter condition seems most likely to produce an enlargement of the ethmoid cells as is commonly seen in a marked deviation of the septum, opposite the middle turbinate. This condition may be confined to the anterior ethmoid cells or it may be extended to the posterior cells, or it may be confined alone to a large accessory cell in the middle turbinate. The cells may continue to enlarge until they not only interfere with nasal respiration, but produce a train of pressure symptoms such as pain, headache, facial and supraorbital neuralgia, eye disturbances, as well as impairment of the olfactory sense. This chronic form of ethmoiditis may remain indefinitely or the enlarged cells may become infected and result in an empyema.

Again, we occasionally find a deformity of the middle turbinate in such a manner that the anterior and lower borders are turned horizontally, pressing either against the outer wall or the nasal septum.

A chronic ethmoiditis may take on a myxomatous condition which may spread throughout the entire ethmoidal labyrinth breaking down the cell walls, separating the two bony walls of the middle turbinate and thus forming a large mass which may interfere with the normal functions of neighboring sinuses.

In the first classification mentioned where there is only an enlargement of the anterior ethmoid cells, producing pressure symptoms or causing interference with the functions of other sinuses, complete exenteration is unnecessary. The enlarged cells can be removed and if the middle turbinate has been pressed over against the septum, then with a Freer elevator slipped up in the olfactory fissure the turbinate can be forced over against the outer wall, making a so-called green stick fracture. Packing is introduced to hold it in this position and allowed to remain thirty-six hours, when it is then removed and nothing further is required but cleansing as the turbinate usually remains in its former position. Should it incline to swing back to its acquired position the packing can be renewed.

There is another class of cases quite commonly observed in which the bulla ethmoidallis is enlarged and the middle turbinate also involved. The two bony walls of the turbinate are separated forming a large accessory cell which may extend to its anterior border but reaches its maximum size posterior to the enlarged ethmoid cell. Here the two bony coverings of this cell are often found making firm pressure against the septum and outer wall

of the nasal cavity. Relief in such cases can be afforded by doing what may be called a plastic operation. The enlarged anterior ethmoid cell is first removed. Then the anterior tip of the middle turbinate is taken away far enough back to make an opening into the accessory cell. If the inferior portion of the turbinate is greatly enlarged, which is often the case, this is also removed. An elevator is then introduced between the outer wall of the cell and the outer wall of the nasal cavity and this cell wall crushed and forced over to the median line. The next step is to bring the inner wall of the cell over in apposition with the other, which is done in the same manner with the elevator. The mucus membrane is then elevated from the inner wall of the turbinate and the bony portions shortened with cutting forceps so the mucus membrane can be brought down to cover them. A gauze packing is introduced on the inner side and carried well forward over the end of the turbinate and allowed to remain about thirty-six hours when much care must be exercised in removing, to see that the flap is not disturbed. It is seldom necessary to repack. Fear might be entertained that this operation would interfere with drainage of the remaining ethmoid cells, but such is not the case as this is taken care of during the healing process.

When there is merely a deformity of the anterior and lower portion of the middle turbinate causing pressure on either wall of the nasal cavity, a complete removal should not be done. Only so much of it as will restore ventilation and drainage and relieve pressure should be sacrificed. If the bony portion of the deformity is not hypertrophied and the mucus membrane covering it is healthy, then fracturing with forceps and bringing the parts in proper position will often give satisfactory results, without removing any portion of it.

An empyema that is of long duration and has not become widely extended does not call for the complete operation. It is always difficult to determine the extent of the diseased cells but a supplemental operation can be performed later if the first should prove to be incomplete and this is greatly preferable to the wholesale destruction of healthy functioning tissues.

When an empyema is extensive and granulation tissue has spread to every portion of the sinus; or when a myxomatous condition has likewise prevailed the parts, then no hope for perfect relief can be entertained without a complete exenteration of the ethmoidal labyrinth. But when only a part of the middle turbinate is involved or a limited portion of the ethmoidal cells diseased, then there is no more justification in doing a complete oper-

ation than there would be in sacrificing an entire limb, when only a portion of it requires amputation. The general surgeon tell us that good surgery consists in saving limbs, not lopping them off. The same principal applies with equal force to surgery of the ethmoid.

It is true that the discomfort to the patient from a complete exenteration is not great, aside from the loss of olfaction and that finer sense of taste that we call flavor for it is through the olfactory sense that this part of taste is enjoyed. But why sacrifice or even impair one of the special senses if it is possible to avoid it?

It must be remembered that the terminal filaments of the olfactory nerve are not distributed to the mucus surfaces throughout the upper third of the nasal cavity, as has been commonly taught. In man only a small area of the upper margin of the middle turbinate directly beneath the cribriform plate and the intervening space is supplied with the olfactory nerve, while in the lower animals where the sense of olfaction is great the ethmoid cells are also supplied. The upper and inner portion of the ethmoid region being well protected is less liable to become diseased than the lower portion and it is usually by extension that it becomes involved. As a rule, therefore, it is the last portion of the ethmoid structure to become diseased as a result of inflammation.

The following case reports can better illustrate the importance of conservation ethmoidal surgery:

Mrs. B., age 65, first came to me about five years ago suffering from the usual train of symptoms due to pressure and interference with sinus drainage and ventilation. On inspection the anterior ethmoid cells on the right side were found to be very much enlarged, as was also the middle turbinate which was resting against the septum. The ethmoid cells were removed and so much of the turbinate as was making pressure and interfering with the functions of the nose. This seemed to give complete relief for some months but while visiting in a neighboring city she contracted a severe cold which seemed to start up anew some of her former discomfort. This operation was performed before I had begun to do the plastic operation and it is possible that too much conservation had been used. She consulted a prominent laryngologist in that city who advised the complete operation which he performed and which afforded perfect relief. On June 18th, this year, she again returned to my office suffering with a similar train of symptoms, referable to the left side. On examination it was found that almost the identical condition had developed as was discovered at the first examination on the opposite side. The large anterior

ethmoid cells were broken down and removed; then the anterior portion of the middle turbinate back to the opening into the large accessory cell which extended far back, causing interference with drainage and ventilation of the sphenoidal sinus. The inferior portion was also removed up to the opening of the cell when the two walls were crushed together as above described. The mucus membrane was then elevated from the inner side of the turbinate and the bony portion slightly trimmed away with cutting forceps to allow the mucus membrane to be brought over the two bony extremities that had already been approximated. The remaining portion of the turbinate was then crowded over to the outer wall and the mucus membrane made to cover as much as possible of the exposed bony surface where the ethmoidal cells had been removed. A thin, narrow strip of gauze was then carried back along the septal side of the turbinate, packing this space first and then around over the end of the remaining portion of the turbinate to hold the flap in position. This was allowed to remain about thirty-six hours when it was removed and daily cleansing for about ten days was all that was required to complete the work which brought about the most happy results that could be desired. From the time of the operation until after the inflammation had subsided the sense of olfaction was entirely suspended. So far, as the patient is able to judge, the sense of smell on the right side where the complete operation was done, is absent, while on the left side where the plastic operation was done, it seems to be normal.

Mrs. N., age 24, came to me the latter part of May, this year, suffering from an acute frontal sinusitis on the left side. She gave a history of having suffered from hay fever for the past two seasons and more or less supra-orbital pain while suffering from colds. Examination showed the bulla ethmoidallis greatly enlarged and interfering with drainage from the frontal sinus. The anterior portion of the middle turbinate was also very large and pressing against the septum, which was so extensively deviated to the right as to almost completely obstruct nasal breathing on that side. Temporary measures were resorted to until the acute inflammation had subsided, and on June 16th, she presented herself for operation. The diseased portion of the anterior ethmoid cell was first removed, then just enough of the anterior and inferior border of the middle turbinate to open into the large accessory cell, was also removed. The mucus membrane with its periostum was then elevated from the inner side of the turbinate and the two bony walls brought together. With a cutting for-

ceps the anterior boney portions were shortened and the mucus membrane brought over to cover them and also to approximate the outer wall high up where the anterior cells had been removed. A packing was introduced as above described and allowed to remain about thirty-six hours, when it was removed and cleansing for a few days was all the further treatment required. The sense of smell, if anything, is improved by the operation and up to last week she had had no return of hay fever this season.

The real test of successful surgical interference in the ethmoid, consists not only in removing the pathological lesion, but in doing it in such a manner as will retain, so far as possible, its normal physiological functions.

—o—

INERTIA UTERI.

DR. E. W. REED, Holton, Kansas.

Read before the Northeast Kansas Medical Society, October 24, 1912.

I wonder what thoughts that brings up in the mind of the general practitioner. Does it bring to his recollection nights of weary waiting? Does he recall nights when the snow and wind cut his face and the drifts were so deep that he could not keep the road, but had to make his way through fields to some woman in labor and then to find only irritating pains with scarcely any dilatation. Probably the call was urgent, but nature was taking her time to do it in her own way.

How many times have you gone to a confinement, made an examination and thought in a few hours that you would be through and ready to go home, yet hour after hour you have waited and finally gone home disgusted, and some other doctor came the next week and got the baby and also the fee.

Probably since long before medicine began to be studied as a separate art, the phenomenon of labor was studied and theories given for its occurrence. And probably those theories were about as good as the theories that have been accepted until within the last few years. Ten years ago when I was a medical student, some of the accepted theories were that it was periodicity. It usually came at the tenth menstrual period after conception. This periodicity was inherited and impressed upon offsprings.

Overdistention of the uterus was also given as an explanation. Take the urinary bladder for instance, when overdistended, it has a tendency to expel its contents and the same with the rectum.

The third reason is the maturity of the ovum.

There is a separation of the tissues of the ovum from the uterus about this time and the ovum acts as a foreign body and is expelled.

However much truth there is in any one or all of these explanations of labor they do not explain why after labor begins that the expulsive power should be so slight that hours and even days would be required for its completion.

Probably after hours of waiting we have given our patients something to eat and told them to take a sleep and rest, and, if necessary, a dose of morphine.

Some of us have given doses of quinine until the roaring in the head masked the pains of labor.

We have all gotten results—at least finally the baby was born either with or without assistance, and the treatment usually gets some credit, if not all.

I don't expect to bring out any new things in this paper. I chose the subject principally to learn something myself, and thought if it were presented at our meeting, possibly it would bring out a discussion that might give me some light in future difficulties.

I have never tried pituitary extract and wondered how much of the claims of the drug houses could be accepted.

Some recent work and observations have brought out some facts that may be of great importance in handling cases of delayed labor.

In August, 1911, Van der Heide had an article in a German medical journal describing some experiments with foetal serum. In some cases where the labor pains had ceased he was able to bring them on again by injection of serum. In other cases he succeeded in bringing on labor pains in gravid women who were supposed to be near the termination of pregnancy. One case in particular was a primipara of 30, who had beginning dilatation, but for days had been no labor pains and in $2\frac{1}{2}$ hours after injecting 4 c. c. of foetal serum, pains began and delivery took place.

Rongy (American Journal of Obstetrics, 1912, Vol. 66), reports 19 cases treated after method of Heide. Uterine contraction occurred in all cases soon after injection. In one case threatened eclampsia was relieved and pains immediately brought on.

Healy and Castle (Journal of Infectious Diseases, Vol. X, p. 244), report experiments made on white rats artificially united in which one was pregnant and the other not. No discomfort occurred until labor began when the non-pregnant showed much disturbance and in some cases death. The disturbance in health of the non-pregnant was least when longest united to its pregnant companion.

In some instances colostrum from cows was found to bring on labor pains in guinea pigs that were pregnant, even if they were not at term.

These experiments seem to indicate that the older theories are only partly right or possibly entirely wrong in explaining the onset of labor.

We all know the psychic effect of any kind of treatment at the period of confinement but laying that aside we certainly have here an indication of the course for future investigation.

What it is that stimulates the uterus to contract? Is it a hormone that causes peristalsis and is it an antigen that is liberated slowly and at the proper time a reaction takes place and the labor pains come in a sort of anaphylaxis?

The fact that fetal blood will relieve eclampsia would indicate that it is more in the nature of anaphylaxis.

Possibly this may lead to other investigations that will bring more practical means than the injection of foetal serum.

The average parturient would probably strenuously object to having from 4 to 10 c. c. of foetal serum from some dead fetus or from the placenta of a woman who might have some communicable disease injected into her veins.

If we can in some way use this foetal blood to develop a serum in the horse for instance, that will react with the antibodies formed during pregnancy, possibly we will have the problem solved.

Until that time I think we must follow the old plan of using quinine or rubber bags or the commoner way, waiting for nature to help the unfortunate woman, out of her difficulty.

I am not going to weary you with any of my cases for you all have them and you wonder why a woman with a pelvis big enough for a small calf should not be able to give birth to a 3 pound baby, yet that is what we have all experienced.

I leave it with you for some information that may help to cut short some of the weary hours for patient and doctor.

—O—

HEMORRHAGES—ANTEPARTUM AND POSTPARTUM.

DR. E. A. REEVES, Kansas City, Kansas.

Lecturer on Obstetrics, University Medical College, Kansas City, Mo.
Obstetrician to Bethany Hospital, Kansas City, Kansas.

Read before the Wyandotte County Society, March 8, 1912.

A profuse hemorrhage occurring prior to or shortly after the birth of the child is always a dangerous and not infrequently a

fatal complication. Practically all cases of antepartum hemorrhages are caused by a premature detachment of the placenta, either partial or complete. This accident is inevitable in placenta-previa and occasionally occurs when the placenta occupies its normal site near the fundus of the uterus.

The etiology of premature detachment of the normally implanted placenta is imperfectly understood and has been given by different authors, as traumatisms, inflammation of the decidua, nephritis, metritis, etc. Multiparity seems to be a predisposing cause as less than 20% occur during the first pregnancy, and the frequency of the accident increases directly with the number of pregnancies. Other etiological factors are: Traction on an abnormally short cord, sudden decreases in the interuterine pressure by the birth of one child in twins, or the escape of a large amount of fluid in hydramnios.

Antepartum hemorrhage is termed, external or concealed, depending on whether or not the blood appears at the vulva. The diagnosis of concealed hemorrhages is sometimes quite difficult, as the symptoms are those of shock, anemia, pallor, rapid pulse, the same as from hemorrhage from any cause, and must be differentiated from advanced extrauterine hemorrhage and those exceptional cases of spontaneous rupture of the uterus.

In concealed hemorrhage the uterus may rapidly increase in size and feels soft and mushy, instead of firm as in the normal uterus during labor, which, would eliminate extrauterine pregnancy, while rupture of the uterus happens during the second stage of labor, premature detachment may happen at any time.

Accidental hemorrhage is one of the most serious complications of pregnancy or labor, practically all of the children and many of the mothers perish. Goodel and Holmes report a maternal mortality of from 32% to 50%, and a foetal mortality of from 86% to 95%. In my two cases the children both perished but the mothers both survived. In the most severe cases the life of the mother can be saved only by promptly emptying the uterus, while in cases of small amount of hemorrhages there may be no perceptible symptoms, and the condition may pass entirely unnoticed. If there are no symptoms of shock these milder cases may be treated expectantly, interference being indicated only when symptoms becomes urgent, then the uterus must be emptied with the least possible delay. If labor has not yet begun it may be necessary to do a manual dilatation, by means of a Champrier de Rebes bag, or by the Harris method, and deliver the child by version with forceps. Here may enter another serious complication,

that must be remembered and provided for. The tonicity of the uterus may be so impaired by over distention or loss of blood, that it fails to contract after delivery and a profuse postpartum hemorrhage ensues, which, in her already weakened condition may destroy the life of the patient in a very few minutes.

The foregoing is termed "accidental hemorrhage" in distinction to "unavoidable hemorrhage", which takes place in placenta previa, when labor comes on and the placenta site dilates instead of contracting, when the placenta becomes detached, and profuse hemorrhage takes place.

In placenta previa, the hemorrhage must be controlled, and the uterus emptied in the most conservative manner indicated by the amount of the hemorrhage and the condition of the patient. Where the loss of blood is not great the vagina wall may be tamponed to cause softening of the cervix and stimulate uterine contractions, or when the loss of blood is more rapid, it may become necessary to do a manual dilatation of the cervix and podalic version, using the breech as a tampon in the lower uterine segment to control the hemorrhage, or in severe cases do an immediate extraction of the child.

Some men of note have recommended Caesarean section for placenta previa at term, and in a few selected cases it might be the best treatment. Such as a primevia, at term, with rigid cervix and a living child with profuse hemorrhage requiring immediate delivery, it might be justifiable in the interest of the child. Such conditions however, are so rare that its field of usefulness must be very limited and a general employment of this method would result in far more harm than good.

Postpartum Hemorrhage.—Except in the very rare accident of inversion of the uterus and an occasional fibroid or myoma in the uterine wall postpartum hemorrhage is almost always due to one of three causes: retention of all or part of a prematurely or partially detached placenta, deep cervical tears involving the deeper tissues of the birth canal and uterine atony, which is very rare.

Etiology.—So long as the placenta remains firmly attached to the uterine wall there can be but little hemorrhage, but as soon as part of its attachment is severed, the vessels are torn across while the partial attachment of the placenta, which remains prevents the free action of the uterus to contract and severe hemorrhage ensues. A small piece broken off the placenta may act in the same way though usually less severe. This condition may follow improper management of the third stage of labor, such as too free and too vigorous use of Credae; traction on the cord, etc.

Occasionally there are deep tears of the cervix extending beyond the vaginal junction into the lower uterine segment or open up the base of the broad ligament or even entire circular detachment of cervix with profuse hemorrhage. These deep cervical tears occasionally occurs during spontaneous delivery, but usually are caused by rapid manual dilatation with extraction in eclampsia or placenta previa, or attempted forceps deliveries through a rigid undilated os or in the occiput posterior position. The cases of true atony of the uterus are no doubt very rare and some writers deny the possibility of such a condition, but we have all seen quite profuse hemorrhages from the momentary relaxation of the uterus after the third stage of labor.

Another very rare cause of postpartum hemorrhage is a paralysis of the placenta site in which the uterus seems firm under the hand and yet the loss of blood continues, but usually when hemorrhages continues after the extrusion of the placenta with firm uterine contraction it is due to laceration of the soft parts.

When due to tears the hemorrhage will be a steady stream of bright red blood and begin as soon as the child is born. If due to retention of part of the placenta the blood escapes in gushes, which are often synchronous with the uterine contraction. If due to atony of the uterus there is a continuous flow of blood which may be so abundant as to destroy life in a few minutes.

The amount of blood lost in a postpartum hemorrhage may vary from 500 to 4000 c. c. although the loss of the latter amount is incompatible with life. Yet the woman in labor can stand with impunity the loss of an amount of blood that would endanger the life of a well developed man. The effect of the loss of blood depends to a great extent upon the condition of the patient, one who is exhausted by a long severe labor may succumb after the loss of 1000 to 1500 c. c. of blood, an amount that would not seriously effect one not so exhausted.

Quite free hemorrhages do not seem to be injurious to the average patient, but often seem to be beneficial, especially to plethoric patients, but when the loss of blood is great the pulse becomes rapid and compressible, the face pallid and drawn, the patient complains of disturbance of vision, chilliness, and shortness of breath in the extreme cases symptoms of air hunger develop and the patient passes into unconsciousness with a fatal termination.

Treatment—If properly managed severe hemorrhage during or after labor should be rare. The most important prophylactic measure is to watch the uterus closely to see that it is firmly con-

tracting and do not attempt the expression of the placenta by Crede too soon, not until the placenta has entirely separated from the uterine wall and the uterus is contracting to expel the now foreign body, as premature attempt at expression of the placenta are frequent causes of imperfect separation. Owing to the tendency in some cases for the uterus to relax after the birth of the child, especially in multiple pregnancies and hydramnios with concealed hemorrhage the uterus must be carefully watched and energetically kneaded upon the least sign of relaxation which usually promptly restores its tonicity. The placenta should be carefully examined as soon as expelled to ascertain whether or not it is intact, and if there are any parts missing, the physician must be prepared to remove same should symptoms ensue. The physician should not leave the house for at least one hour after the birth of the child. If no hemorrhage has occurred in that time and the uterus is still firmly contracted there is usually little danger. In the presence of actual hemorrhage the treatment depends upon whether or not the placenta has been expelled. If not, the fundus should be kneaded firmly, if the uterus contracts and controls the hemorrhage, all is well, if not, attempts should be made to deliver the placenta by Crede, failing in this it may become necessary if the patient's condition is alarming to manually remove the placenta, which is always a dangerous procedure on account of the liability of sepsis and every precaution must be taken against infection. If the hemorrhage does not cease after the delivery of the placenta the sterile hand should be inserted into the uterus to search for any parts that may have been left behind. The hand usually is an efficient irritator, and the uterus contracts down firmly over it. The hand should not be forcibly withdrawn for fear of inversion, but allow the uterine contractions to expel the hand. If the hemorrhage is from deep tears of the soft parts they should be closed by suture or the bleeding controlled by firm packs. In atony of the uterus, which is rare, a hot interuterine douche of sterile water or saline is often efficient, if this fails the uterus must be packed firmly with sterile gauze, which not only makes pressure on the bleeding vessels but stimulates the uterus to contract. This pack should not be left in place longer than twenty-four hours when it is removed by gentle traction of the free end.

Formerly ice, vinegar, iron, etc., were introduced into the uterus but under our present knowledge is hardly justifiable on account of the danger of sepsis and the difficulty in removing the firm clot formed by the action of the iron.

Every obstetrician should carry the articles necessary to

cope with postpartum hemorrhage, as time is precious and they often cannot be obtained promptly in an emergency. After the hemorrhage has ceased the condition of the patient must be looked after, if shock is not severe, raising the foot of the bed and the application of heat may be all that is needed. In more severe cases moderate doses of either strychnine or ergot may be indicated or hypodermic injections of whiskey or ether, enema of hot black coffee and saline are beneficial. When the loss of blood has been great the injection under each breast of 1000 to 1500 c. c. of hot saline solution is a most efficient restorative, occasionally tightly bandaging the limbs or compression of the aorta may be restored to but are seldom necessary if the proper preparation has been made to meet the emergencies that some times arise.

Too much stress cannot be laid upon the necessity of absolute surgical cleanliness as far as interuterine manipulations are concerned as far as possible, because if we save our patient from hemorrhage and have her die a few days later from sepsis, we have accomplished little.

Therefore, except in the most urgent cases where a very few minutes may destroy the life of the patient, we would better take the time necessary for the proper preparation before, as to run the risk of sepsis following.

—o—
SINUSITIS.

CLARENCE ZUGG, B. S., M. D., Kansas City, Mo.

Oto-Laryngologist, Bethany Hospital: Assistant Ophthalmologist, St. Margaret's Hospital.

We will not burden you by attempting to give an anatomical description of, if not the most complexed, the most irregular structures found in the human mechanism. However, too great stress can not be laid on the importance of a thorough knowledge of their anatomy and relation to vital structures, to him who attempts operative procedures. This can only be acquired by extended, careful training on the cadaver and the living subject under the guidance of a master.

For the purpose of this paper be it sufficient to state the characteristics in common to the nasal accessory sinuses and that what is said refers in particular to inflammation of the sinuses or cells of the ethmoid.

1. All accessory cavities of the nose have bony walls, which do not collapse, and are normally filled with air.
2. They all are connected with the nose by small openings

the purpose of which, judging from their location and size, seems to be more for the purpose of ventilation than drainage.

3. Over each of these openings is located some other structure covered with mucous membrane and erectile tissue; the slight swelling of which will completely close them.

4. The mucous membrane lining these cavities have a rich blood supply and that these vessels quickly respond to irritation or vasomotor disturbances and pour out a copious discharge.

As to duration sinusitis may be either acute or chronic.

As to cause it may be either local or systemic, or both.

As to character non-suppurative or suppurative.

There is a difference of opinion as to the cause of non-suppurative sinusitis; some believe it to be of bacterial origin of such a low grade that suppuration does not result. Others believe it to be due to prolonged irritation from any cause with probably a constitutional predisposition. While still others observers believe it to be due to a closure of the ostium by any enlargement or swelling of over laying structures; after which the air is absorbed a partial vacuum would result were it not for the fact that the negative pressure brings an increased amount of blood and serum to the mucous membrane lining the cavity which produces a swelling in many cases to completely fill the cavity. This seems to me to be at least one, if not the only one of the principal factors. At this stage the condition is exceedingly favorable for infection to take place and suppurative sinusitis results. If infection does not result the prolonged congestion causes a proliferation of connective tissue, which in turn may result in one of many forms of degeneration.

The causes of sinusitis may be divided into two groups, namely:

1. Exciting.
2. Predisposing.

Exciting causes are infections, injuries due to chemicals and trauma.

As to infection by pathogenic organisms; it is a well established fact that they do not cause inflammatory reactions so long as the cells of the body are normal, with the possible exception to exceedingly virulent infective agents. The truth of this statement is shown by the well-known fact that the upper respiratory tract is the habitat of many virulent bacteria which are harmless until the resistance of the cells is lowered. Bacteria may gain entrance to a sinus from the air, by way of the blood and lymph stream or by continuity of tissue.

In considering the predisposing causes of sinusitis it is well to

remember a physiological law which is so well stated by Ballinger, namely: when the drainage and ventilation of a mucous membrane lined cavity is impaired or blocked, the conditions are favorable for the growth of pathogenic bacteria; in other words we have a suitable pabulum, suitable temperature and moisture—each accessory sinus making an excellent incubator.

The predisposing causes of sinusitis may be considered as either extranasal or intranasal.

Of the extranasal causes may be mentioned age, sex, climate, exposure, improper clothing, systemic and constitutional disease, and adenoids.

Of the intranasal predisposing cause by far the most important is obstruction.

The most common obstructions are due to cartilaginous deviations of the septum, including spurs and ridges, soft hypertrophy of the septum, enlarged inferior turbinates, enlarged middle turbinates, enlarged bulla ethmoidales and uncinate cells.

High obstructions are far more productive factors in sinusitis than those low down, of course the location and character of the obstruction has much to do in predisposing certain sinuses to disease as it does also with the line of treatment to be instituted after disease has developed.

Pain is a frequent symptom although not always present. It is usually of a reflex character and referred to some of the branches of the fifth nerve. This explains many of the so-called facial neuralgias. Pain in the maxillary antrum may be local or referred to the teeth, the ear, or eye, or produce a unilateral frontal headache. We have had patients come to us after having teeth extracted without relief from pain only to find a diseased antrum.

Others after repeated attempts to be fitted with glasses to find the trouble due to inflammation in the antrum, frontal or ethmoidal cells. Though in frontal sinus disease the pain is usually localized and frequently diagnosed as a supra-orbital neuralgia.

The pain in ethmoid disease may be local, and is usually described as a deep seated headache or referred to the eyes or supra-orbital region. The pain in sphenoid disease is frequently referred to the occipital region.

In the non-suppurative form there may or may not be a discharge. When the discharge is present it is clear and watery or mucous in character and usually not constant. In the suppurative form the discharge may be muco-purulent or purulent.

Pain and headache as spoken of above is suggestive. That due to sinus disease must be differentiated from headache caused

by eye strain and systemic diseases. If using the eyes brings on the headache and resting the eyes relieves it, it is almost certain to be due to eye strain. Hemicrania and headache increased by taking cold which lasts through the night while the eyes are at rest is due to either a systemic condition or nasal accessory sinus disease.

Transillumination is valuable in the diagnosis of the suppurative form of frontal sinus, ethmoid cell, and antrum disease; but can not always be relied upon in the non-suppurative form. The X-Ray is highly recommended, but personally my experience with this agent as a means of diagnosis has been quite limited.

A suction apparatus is valuable in the suppurative form and non-suppurative form when a discharge is present.

The most valuable aid and the one by which the diagnosis is clinched is the rhinoscopic examination. This should be systematic and thorough. And do not be too certain that you have a maxillary sinus disease because you find it full of fluid or pus. Frequently we have seen this when on further examination it was found that the antrum only was acting as a catch basin for a discharge coming from the frontal sinus or anterior ethmoidal cells.

The treatment of these diseases is based on the condition present. If the trouble is due to closure of the ostium, drainage, cleansing the cavity a few times, and provisions for its ventilation usually are sufficient. This applies especially to the maxillary and sphenoidal sinuses, and may be either medical or surgical as indicated.

When polypi are found growing from the middle turbinate or under it, the indication is usually to remove the middle turbinate as the first step in the treatment. For removing the middle turbinate I have found Andrews' guarded turbinate chisel and Bosworths' snare the most practical.

For removing the ethmoidal cells Knights' cutting forceps are very satisfactory. In this operation care should be taken in cases where the middle turbinate has to be removed, which is usually necessary, to use a cutting and not a tearing instrument to cut along the neck of the turbinate. In removing the cells every effort should be made to avoid injuring that part of the meatus nasi communis which contains the distribution of the olfactory nerve. This is the upper part of the septum and the plate that forms the median wall of the ethmoid labyrinth. This is accomplished by leaving the median plate standing. If this precaution is taken the cribriform plate will also be free from injury. Meningitis occurs not from extension through the roof of the labyrinth, but by way of the cribriform plate which is much more delicate and has been broken

through, or because infection extends along the sheaths of the olfactory nerves or along the blood vessels and lymphatic communication between the olfactory region in the nose and the meninges. Therefore, the great importance of avoiding injuring these parts.

Packs should not be used after ethmoid operations only to control hemorrhage and even then should not be left in place for more than 24 hours without removal, when a fresh pack can be placed if necessary.

REFERENCE:—Ballinger, A. H. Andrews, Schambaugh.
713 Gloyd Building.

FOREIGN BODIES IN THE AIR PASSAGES AND THE OESOPHAGUS.

DR. R. H. T. MANN, Texarkana.

Read before the Medical Association of the Southwest, Oct. 9, 1912.

The character of foreign bodies to be removed will differ very much with different physicians, depending on whether the patients come from urban or rural districts. The physician whose clientele is largely urban, will be called upon to remove articles such as collar buttons, and safety pins, while the one whose clientele is rural will be called upon to remove grains of corn, cockle burs and water melon seed.

Foreign bodies which find their way into the larynx, trachea and bronchi, are usually placed into the mouth and during a sudden act of laughing are drawn into them.

The diagnosis is not always easy. If the foreign body is located in the larynx the diagnosis can easily be made with the laryngoscope. If, however, it is in the lower part of the trachea, the bronchi or esophagus, the diagnosis may be very difficult. If the foreign body consists of a metallic substance, the diagnosis can be made with the X-Ray. If, however, it consists of a vegetable seed the X-Ray is of no service. Here the diagnosis must be made from the history of the case and the stethoscope, which is very useful and in many cases very reliable. The stethoscope is of course of no use with foreign bodies in the oesophagus. Here one has often to make the diagnosis from the history of the case, or combine it with the oesophagoscope.

In all cases in which there is a reasonable doubt that the foreign body is located in the oesophagus, a very careful examination should be made with the oesophagoscope.

The method to be used in the removal of foreign bodies will

depend upon their location. If located in the larynx they can usually be removed with little difficulty with a pair of forceps, unless they are imbedded and cause considerable obstruction to breathing, in which case it may become necessary to do a tracheotomy. If located in the lower part of the trachea and some of the divisions of the bronchi, many difficulties and dangers are presented, especially is this the case in children under two years, where it is almost impossible to pass the smallest bronchoscope through the larynx, and indeed, it is often difficult to introduce it into the trachea after a tracheotomy has been performed.

The tracheotomy is the most dangerous part of the operation in babies and here it is absolutely essential. The first danger is the anesthetic. Local anesthesia is far safer and should be the one selected. The second danger lies in not having completely controlled the hemorrhage before the trachea is opened. The trachea should never be opened until all bleeding has ceased.

In my five patients with foreign bodies in the lower part of the trachea and bronchi, two occurred before the 2nd year, two before the fifth and one before the 9th year. Tracheotomy has been the method in vogue for the removal of these bodies from the lower air passages for many years. Bronchoscopy achieves its greatest triumph when it is used as a supplement to tracheotomy. After the tracheotomy has been performed or even before the trachea has been opened, if the patients general condition is not good, it is well to discontinue the operation for a few hours, after which time the operator can proceed with comparative safety.

Small children suffer very much from shock. They also revive quickly and it is far better to do this operation in two or three steps than to submit these little patients to too long and severe shock. Few of these patients will be lost immediately from suffocation, as foreign bodies which are small enough to pass through the larynx and lodge at the lower part of the trachea and bronchi usually leave sufficient breathing space to sustain life for a while.

Bronchoscopy consists in passing a straight tube of suitable size into the bronchi, either through the larynx, known as upper bronchoscopy, or through the tracheal wound, known as lower bronchoscopy. Upper bronchoscopy is far more difficult than lower bronchoscopy and in certain patients with short necks or far projecting teeth, is almost impossible. It should be attempted only on adult patients.

Oesophagoscopy consists in passing a straight tube through the oesophagus. When the tube has thus been passed, with a suitable electric light a good view of the parts can be obtained. It

matters little the kind of light used. This may depend upon the choice of the operator. I use the Kirstein light and the Killian tube for I am thoroughly familiar with these.

Where a general anesthetic is not to be used, a judicious use of cocaine will greatly relieve the distress of the patient in either of these procedures.

Within the last few years I have seen nine of these patients.

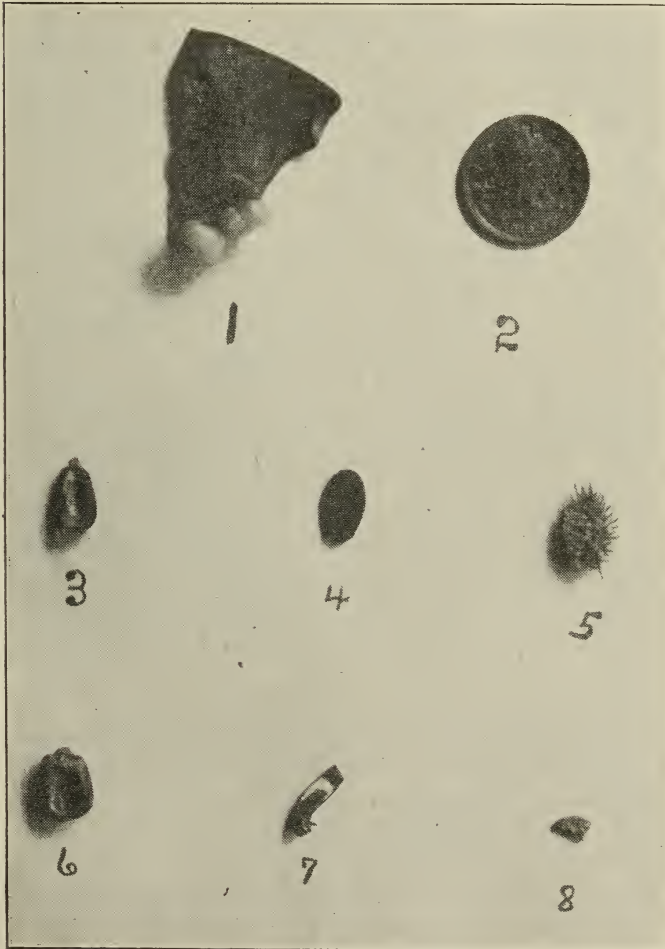


Plate 1. Removal of part of false plate with two teeth from 10 inches down oesophagus in a woman 40 years of age. Method—oe-

sophagoscopy. With the oesophagoscope and a pair of forceps the teeth and plate were successfully withdrawn.

Plate 2. Was removal of nickel from upper part of oesophagus of a $2\frac{1}{2}$ year old child. Nickel was located with X-Ray and with a pair of forceps the nickel was grasped and removed.

Plate 3. Removal of grain of corn from left bronchial tube of a 4 year old child. Method—tracheotomy. Corn was located with broncoscope, successfully removed with forceps.

Plate 4. Water melon seed from right bronchial tube of 16 months old babe. Tracheotomy. Seed located with bronchoscope and removed with forceps.

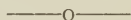
Plate No. 5. Cockle bur removed from larynx of 12 year old boy. This bur was stuck to both vocal cords and almost occluded the larynx. It was very firmly imbedded in the vocal cords. I had to perform a tracheotomy and with a strong pair of forceps succeeded in removing the bur.

Plate No. 6. Grain of corn, removed from trachea of 8 year old boy. Tracheotomy. Corn located with bronchoscope and removed with forceps.

Plate No. 7. Part of grain of corn. On this child a tracheotomy was performed. A very diligent search made with bronchoscope but corn could not be found. On account of the general condition of the child, search was deferred until condition could be improved. During this time while the nurse was cleaning tube, the child coughed up the corn through tracheal opening.

Plate No. 8. Piece of uncooked sweet potato from right bronchus of 8 months old babe. Method—tracheotomy and bronchoscopy. Removal with forceps.

This method has been tried on the eight patients above enumerated. It has been successful in each case and there have been no fatalities.



The Treatment of Interstitial Keratitis by Salvarsan.—Vandegrift (Medical Record, October 26, 1912), treated three pronounced cases of interstitial keratitis by salvarsan, which was introduced in an oil vehicle intramuscularly. He notes that salvarsan worked so quickly that little connective tissue had time to form. In each case the corneal infiltrate even after subsidence of all the inflammatory signs had been absorbed to a much greater degree than could be hoped for with mercury. We do not expect to absorb the old scars of a past interstitial keratitis with salvarsan or by any other treatment, but if salvarsan is used when the least trace of acute symptoms is present it will not only check the inflammation but will absorb the infiltrate and prevent further deposit of connective tissue.—Therapeutic Gazette.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY, - - - - **EDITOR.**

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1905, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

The friends of Dr. Crumbine are very glad the investigation was made. It placed the department in a much better light before the people. The Doctor was absolutely vindicated in every particular and it made more clear than this fact, that the knockers against the board of health came from the fellows that had been caught with the goods on them and prosecuted for violating the laws. The majority of kicks came from firms that were fined for violating the Food and Drugs laws.—C. S. K.

—o—

In the very last hours of the session the legislature passed a bill re-appropriating the unused Tuberculosis Sanatorium fund of about \$49,500. It is now assured that the state of Kansas will have an institution in which tuberculosis may be treated. The Governor has already appointed the Advisory Commission consisting of Dr. J. A. Milligan, Garnett; Dr. J. J. Sippy, Belle Plains; Dr. M. M. Hart, Mackville; Dr. W. N. Bauer, Sylvia; Dr. S. J. Crumbine as secretary of the state board of health is the other member. At one time it looked very doubtful whether or not the legislature would offer any assistance—in fact the senate went so far as to repeal the act of 1911. But the House would not concur with the result that the appropriation was made as stated.—C. S. K.

The annual meeting of the state society at Topeka, May 7-8, holds out great promise. The Shawnee county physicians are promising "big things" and it can be said here and now that they always make good. There will be a banquet and other entertainments with which the committee is planning to surprise the members.

The entertainment will be a distinct feature.

The society will have as guests, Dr. Allan B. Kanavel of Chicago and Dr. Wm. Engelback of St. Louis, who will deliver addresses. The society is fortunate in securing them. Probably one of the subjects that will excite the most discussion will be a symposium on "Medical Legislation" dealing largely with what the last session of the legislature did to us. The entire time of the meeting could easily be taken up with this subject if every one present would be allowed to have his say. However, the subject will be ably presented and no doubt will be warm.

The scientific meetings will be held in Representative Hall at the State House. The National hotel will be the headquarters.

PROGRAM FOR THE ANNUAL MEETING OF THE KANSAS MEDICAL SOCIETY.

TOPEKA, KANSAS, MAY 7-8, 1913.

ENTERTAINMENT.

Evening of May 7th, by Shawnee County Medical Society at Representative Hall.

Evening of May 8th, Luncheon and Clinics at State Hospital.

"The Treatment of Diphtheria," Dr. W. R. Heylman, Iola.

"Plastic Surgery of the Face," Dr. W. S. Sutton, Kansas City.

"Malignant Papilloma of Ovary, With Report of Case," Dr. C. C. Nesselrode, Kansas City.

"The Surgical Situation in Kansas from the General Practitioners Standpoint," Dr. T. A. Jones, Liberal.

"Auto-Intoxication," Dr. M. S. Thacher, Turon.

"Pathology of Chronic Arthritis," Dr. L. S. Milne, Kansas City.

"Obstruction of the Upper Air Passages," Dr. J. R. Scott, Newton.

"Neurasthenia," Dr. W. T. Grove, Eureka.

"Rectal Surgery Under Local Anesthesia," Dr. Arthur E. Hertzler, Halstead.

"Veratrum in Eclampsia," Dr. F. M. Wiley, Fredonia.

"Gall-Bladder," Dr. E. O. Hubbard, Shawnee.

"Dietetics in Typhoid Fever," Dr. W. C. Harkey, Lenexa.

"Modern Diagnosis of Syphilis," Dr. H. M. Connor, Topeka.

"Blood Pressure and Its Significance," Dr. W. E. McVey, Topeka.

"Blood Examination," Dr. S. A. Hammel, Topeka.

"Artificial Pneumo-Thorax in the Treatment of Pulmonary Tuberculosis," Dr. E. S. Bullock, Silver City, N. M.

"The Present Approved Methods of Treatment of Dacryocystitis," Dr. E. N. Robertson, Concordia.

"Abnormalities of Speech in Children," Dr. E. M. Seydell, Wichita.

"Aural Vertigo," Dr. M. L. Perry, Parsons.

"Cancer—Is its Contagious?—Short Review of Subject—Report of Cases," Dr. J. C. Kirby, Cedar Vale.

"What are we Going to do About It"? Dr. Chas. M. Seiver, Holton.

"Jaundice," Dr. W. F. Fairbanks, Kansas City.

"Pseudoleukemia," Dr. Halph R. Hertzler, Newton.

Recent Developments in the Diagnosis and Treatment of Nephritis," Dr. Wm. Engelbach, St. Louis.

"The Medical Man in the Legislature," Dr. J. S. Cummings, Bronson.

"What I Accomplished as a Member of the Legislature of 1913" Dr. J. B. Scott, Jetmore.

"Experience of Three Doctors in the Kansas Legislature," Dr. J. T. Nichols, Liberal.

"Theoretical vs. Practical Politics in Medical Legislation," Dr. J. J. Sippy, Belle Plains.

Paper—Dr. E. E. Liggett, Oswego.

Paper—Dr. W. G. Jack, Chautauqua.

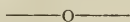
Paper—Dr. J. C. Shaw, Holton.

Paper—Dr. H. W. Horn, Wichita.

Paper—Dr. E. M. Martin, Clay Center.

Paper—Dr. F. A. Carmichael, Goodland.

Paper—Dr. Allan B. Kanavel, Chicago.



WHAT HAVE WE LOST?

Now that the legislature has adjourned it might be well to invoice our situation and try to determine just how much of a loss we have sustained. Before we had any efficient law governing the practice of medicine in Kansas some people would employ the most illiterate quacks and veriest tyros in preference to well

qualified physicians, because we thought they were unable to distinguish. We believed the State should guard its inhabitants against their inability to distinguish the good from the bad and we urged the passage of a law which would put the state's guaranty of efficiency upon any one who was permitted to practice medicine.

To thoughtful men such a law did not promise any benefit to the profession in the way of diminishing competition for we all knew that for every quack put out of business there would be one or more qualified physicians added to the field. In fact the effect of the law was to strengthen competition rather to weaken it. The law did however, help very materially in advancing the standard of medicine in Kansas and placed the profession on a plane with that in other states. During the past few years, by careful nursing in the legislature and by the efforts of competent and energetic officers of the Board of Examiners, the law has become very satisfactorily effective and the medical profession of Kansas ranks as high as that in any other state in the union. This of course, is a matter for congratulation, but is not directly of so much importance as the fact that reciprocity arrangements have been made with a majority of the state boards, so that a Kansas certificate will be accepted nearly everywhere. This most satisfactory condition of affairs is now most seriously threatened by the recent act of the legislature. It is to be hoped however, since the requirements for admission to practice real medicine have not been changed and since the Board will no longer be required to recognize the osteopaths, that its certificates will still receive their deserved recognition. If this shall prove to be the case, what have we lost?

We believed at one time that the people ought to be protected against the ignorant and unqualified men who pretended to practice medicine. We were certainly right in that, but if we believed that the people desired to be so protected the strong support given the chiropractors by the representatives of the people and the thousands of names upon petitions in their behalf should certainly convince us of our mistake. The people evidently want the osteopaths, the chiropractors, christian scientists, etc., etc., to be unhampered by any restrictive legislation.

But how does it affect the medical profession? Can the osteopath or the chiropractor cure any disease that a physician has failed to cure? Have they any successful methods for treating disease that physicians do not understand? If so let us get busy and find out what they are. If they succeed where we fail suppose we try to learn why and how we failed.

If the osteopath or the chiropractor gets business away from

you that you ought to have, possibly you have not shown quite the interest you ought to have shown. If an incurable case has gone to one of these men, you must remember that people, in their extremity, are ready and willing to try anything and they want things to try.

I am sure there is one direction in which physicians might make profitable improvement. We are entirely too charitable, too ready to give our services for the asking; too easily imposed upon by the assumption or the appearance of poverty. The people apparently feel that they owe us no consideration and it seems to me that it is about time we put our affairs upon a business basis. I wonder if the osteopaths and the chiropractors give their services to the poor afflicted with as ready a hand as do physicians.

It strikes me that we have always made a failure in politics and it is time that we drop out of the game entirely and give our attention to medicine. In fact, the atmosphere of the last legislature was very unwholesome for us. There seemed to be a feeling there that we had shown entirely too much political activity for the good of our legitimate work.

W. E. M.

—o—

RIGHT OR POLICY?

Disappointment falls heavily upon those who expect great benefits from the successful termination of any political controversy in these times. Possibly we are inclined to load our recently elected governor too heavily with blame for our fallen hopes. Before we accuse him of insincerity it might be well to know if Mr. Hodges had in any manner pledged himself to favor the interests of the medical profession of the state.

The attitude of Mr. Capper for some years prior to his candidacy led the profession, not without reason, to believe that he was not in sympathy with the progressive policy of modern medicine. The physicians of the state pretty generally opposed Mr. Capper for this reason. Their attitude in the campaign was therefore one of opposition to Mr. Capper rather than support of Mr. Hodges, for if the latter had in any way expressed a sympathy with the desires of the medical profession such fact was not generally known. They were willing to take a chance with a man whose sentiments they did not know rather than with a man whose sentiments they fully believed they had good reason to fear.

Let us be honest with ourselves as well as with the Governor. Does he owe his election to the physicians of state any more than he owes it to the "Regular" Republicans and various other factions that for one cause and another gave him their support? A large

majority of the physicians of Kansas undoubtedly voted for Mr. Hodges and they undoubtedly influenced many votes in his favor, but without a good many thousands of the 'Regular' Republican votes he could hardly have been elected. I have no doubt he is very grateful to the physicians for their votes and for their influence. Now the chiropractors are not themselves very numerous but apparently they had friends in plenty and apparently a great majority of these also voted and worked for Mr. Hodges. He is no doubt grateful to them also for their votes and their influence. They were asking for legislation for their own benefit and they succeeded in getting the legislators to pass their bill. They would have called it ingratitude had the Governor vetoed their bill and they are perhaps justified in calling his refusal to sign the bill ingratitude. On the other hand, we, to whom he is no doubt also grateful, were not asking for legislation, but asking that the desired legislation be refused the chiropractors. Shall we therefore say he showed ingratitude to us because he did not show more ingratitude to them.

Possibly the Governors attitude in this matter was determined by the amount of gratitude he felt toward the different factions, but for us to suggest that we expected him to veto that bill out of gratitude to the physicians for their efforts in his behalf is putting rather a low estimate upon the standard of morals and equity by which we expect a governor of this great state to be guided. Medical men whose lives are devoted to the serious problems of life and death do not readily comprehend political policies. They still hold to the old idea that men should do what is right because it is right and consider neither reward or punishment. I doubt very much if our governor is big enough to adhere closely to so rigid a policy, and there are very few men in politics who are. In fact, the man who would subordinate his political judgment to his sense of right and wrong would last about as long in politics as a snowball in—Texas.

I am sure no one will accuse the governor of having believed that it was right to permit the chiropractor's bill to become a law. Such an accusation would impute a lack of intelligence or a lack of comprehension inconsistent with the political sagacity he has shown; or it would imply a lack of familiarity with present conditions certainly inexcusable in one so honored by the people. No one could make such an accusation, however, in the light of the governor's action in the matter, for his political judgement having determined the policy of allowing the bill to become a law, if his conscience had told him it was also right he would certainly have approved its passage with his signature.

What further humiliation the medical profession is destined to suffer in order to satisfy the political exigencies of a reincarnated Democracy can only be surmised. It is to be hoped however, that the governor still has sufficient friends in the profession to make up a full crew for his Ship of State without calling upon our Missouri contingent to supply the deficiency. W. E. M.

—o—

In a previous issue we remarked that "The Regular Medical profession had made it possible for Mr. Geo. H. Hodges to occupy the position of governor of the state of Kansas and it remains to be seen whether their action was wise, or otherwise."

Were it possible to now go back and have the election over again, who would fill the Gubernatorial Chair after the votes were cast? Arthur Capper without a doubt. The Doctors knew where Mr. Capper stood in the past and combined to defeat him on account of his countenancing quackery in the columns of the Capital.

How many votes would Mr. Hodges get today from the Medical profession for any office to which he might aspire? I think not a bakers' dozen. It is of no use for Mr. Hodges to assure us that he did not sign the bills for the osteopaths and chiropractors, whereby hundreds of unprincipled and uneducated fakirs will be permitted to parade as doctors and jeopardize the health and lives of the innocent public. No—we would have thought more of him had he done so and not played the "Pontius Pilate" act. He simply played Rabbit, in the parlance of the legislature.

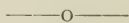
Every regular physician, that believes in the tenets of his profession, should from now on make it his business to create a sentiment amongst his people, friends, neighbors and patients, against this man who evidently is willing to forego his principles for politics. Any man that will so deliberately throw down the men that put him where he is and take up with the very people that supported his opponent and fought him day and night, should be taught that there are some two thousand doctors, that have spent money and years to acquire their profession, who will remember the betrayer of their confidence.

So far his appointments are the same as were his predecessors in office; every one purely political and for political purposes. Has he made any effort to ascertain from the bulk of the profession a list of men fitted to fill vacancies on different state boards? Decidedly not! Does he care whether the profession likes it or not? Decidedly not! Has he so far proved himself as having the courage of his former convictions? Decidedly not! Has he so far shown himself in harmony with education and the learned

professions? Decidedly not! Has he so far proved himself a safe man to tie to or vote for? Decidedly not!

It behooves the members of the medical profession to begin now and keep up the fight and prepare for his Waterloo in 1914.

C. C. G.



Some of the newspapers of the state think they have a great joke on the physicians of Kansas because of the fact that the physicians defeated Capper for Governor and elected Hodges, and now this new Governor and legislature have made laws that lower the standard in Kansas and make it the laughing stock of the country.

We physicians voted against Capper from principle and would do it again. True, we have been disappointed in our new administration but that is not our fault. The members of our state medical society are the men who stand for efficiency and education and decry quackery and fraud at every opportunity; but we have done our whole duty.

Why is it that a mere handful of persons in Kansas called chiropractors can get a bill through the legislature and then select their own board when the Kansas Medical Society composed of nearly two thousand of the best educated men in the State, has never been consulted by any Governor of Kansas, except Governor Stanley, about whom should be appointed on the Board of Health or the Examining Board of the state?

Has there ever been any legislation in the state of Kansas for the prevention of diseases, sanitation or anything in the way of health, to benefit the people that has not been put there by the hard work of the Kansas Medical Society, through its committees?

Why is it that the chiropractors, the osteopaths, or any other paths, can get what they want from the legislature when the Medical profession, that has never asked for anything that would benefit it financially but only for such legislation as would require better education and more efficiency of its members, and what would aid in prevention of diseases, has to fight to get anything through?

Is it that the American people like to be humbugged and that the members of the Kansas legislature are no better than the average American citizen? The answer might be yes and the truth. Still is not ignorance a better answer?

Many persons intelligent on every other subject are ignorant and superstitious when it comes to medicine or treatment of

diseases else why do so many good men flock to the fakirs. Can we not accomplish more by education? Let us not forget our political duties but we must educate. The education furnished by the state board of health about tuberculosis has saved three hundred lives a year in Kansas, yet the present legislature seems to think three hundred lives a year are not worth the few dollars expended to save them and so put an end to such education.

If the state of Kansas retains its standing in the medical profession, the Kansas State Medical Society will have to keep it there. Let us begin to educate the people. They need it.

W. F. S.

**MAY 7-8 IS THE DATE—TOPEKA IS THE PLACE AND
THEN THE BEST MEETING EVER!**

I have before me the first annual report of the division of vital statistics of Kansas.

It is very interesting and illuminating both from the thoroughly efficient way in which it is prepared and for the facts which it sets forth.

The number of births were 38,000 which is a birth rate of 22.47 per thousand. Deaths 17,183 which makes a death rate of 10.16 per thousand. The deaths are classified according to age, sex, color, social condition, nationality into eighty-six subdivisions of occupations, and in the causes of deaths the International Classification is used.

Examination into the cause of death indicates that the most serious epidemic disease has been whooping cough which shows 156 deaths, next comes diphtheria with 121 deaths, scarlet fever with 60. Typhoid fever 345 deaths, but shows no wide spread epidemic at any point.

It is indeed gratifying to know that the report shows but 1082 deaths from tuberculosis, a death rate of 64 per 100,000 compared with a death-rate for the registration of the U. S. in 1910 of 160 per 100,000. We are unable to make comparisons with the death rate, from this cause, in former years in this state, but the saving to the state of 700 lives when compared with the rate in registration area is undoubtedly due to the good work carried on during the past few years by the board of health in its campaign against tuberculosis.

Deaths from cancer in all forms reach the alarming figure of 1056. If there is anything the medical profession can do in the way of warnings and education of the people along this line surely we ought to be up and doing.

Organic heart disease is the highest of any cause of death, there being 1436 deaths attributed to this cause.

Pneumonia claimed 1345 victims which seems high but figures 79.1 per 100,000 as compared to 147.7 per 100,000 for the registration area. Bad milk and bad feedings are shown in 764 deaths from diarrhea and enteritis in children under two years of age.

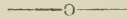
Bright's disease and nephritis show 1057 deaths. The diseases of early infancy show 1457 deaths, which when compared with the registration area is high.

There were 1250 deaths due to external causes of which 207 were suicide, 82 were murder and 961 accidental.

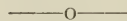
It would be interesting to ascertain how many of the total deaths were due to preventable causes and it is largely from lack of help and money which prevents our Registrar, Mr. Deacon, from collecting these facts. In our registrar we certainly have a man full of enthusiasm and a genius for this kind of work.

The Board of Health has now an epidemiologist by whose services very much valuable data will be at our disposal by the end of another year. I want to congratulate the profession and people of the state in the preservation of our efficient Board of Health.

O. D. W.



Doctor, your attention is called to the advertising pages of our Journal. As you have been informed we do not accept any advertising not approved by the council on Pharmacy and Chemistry of the American Medical Association. This necessitates the refusal of a large amount of advertising in fact we could more than double the amount we now carry which would make the Journal pay the society a good profit above all expenses. Now, you can by patronizing our advertisers know that you are receiving the best products on the market and thus help the advertisers to realize on their investment. This will help us to secure more advertisers and therefore materially help to swell the receipts. If this can be done we will all be the gainers. Lets see if we cannot all pull together and accomplish this result.



Misapprehension as to the Novelty of the Friedman Treatment.

—In view of the newspaper sensation caused by the announcement by Dr. Friedmann of another "cure" for tuberculosis, The Journal of the American Medical Association, in a recent editorial, reviews the facts. The use of live cultures in the treatment of tuberculosis is by no means a new idea. In 1892 and 1893, Trudeau of Saranac Lake was the first to announce that living cultures must be used in order to produce an efficient immunity against

tuberculosis. DeSchweinitz in 1894, Pearson and Gilliland in 1905, Webb and Williams, all used living cultures. If we go to foreign publications it is easy to multiply instances of the use of living cultures. In 1901 McFadyean and von Behring and in 1903 Thomassen used living cultures to produce immunity in cattle.

The excitement of the public over Friedmann is hard to understand except on the basis of clever press-agent work. Practically every fact which he has brought forward has been known for years. Why the bacillus from the turtle should possess special curative value for the human being is a mystery, although, of course, it cannot be denied that it is within the range of possibility that such a thing is true. The point of scientific interest that should be made clear, however, is that he has discovered no new principle, at least as far as the published communications go. The principle of using slightly virulent cultures derived from another species was demonstrated by Trudeau in 1891 and 1892. The principle of intravenous injection for the best production of immunity against tuberculosis was demonstrated by Pearson and Gilliland and others in 1902. It seems, then, that if he has discovered anything at all it is only a culture which possesses unusual immunizing powers for human beings. Practically, the point of interest is in the question whether or not a harmless and clinically efficient immunizing culture has actually been worked out. On this point we still await authoritative tests, for we have no information that Dr. Friedmann has yet submitted his treatment to investigation by competent and unprejudiced experts in the treatment of tuberculosis. If it proves its worth under adequate, unbiased scientific investigation, the medical profession will be only too glad to forget the unfortunate features in its exploitation which have raised a presumption against its worth. Until then, the public and the profession alike may be pardoned for remembering that a patent was applied for and the treatment advertised before its value was established, that as yet we have the word of no one who has actually tested it except Dr. Friedmann and his assistants, and, finally, that, although there is no lack of clinical material for testing the treatment in Germany, he has chosen to bring it to America first from no other apparent motive than pure commercialism.

The following from the Journal of the Indiana State Medical Association is a reminder of the type with which Kansas will soon be burdened.

THE CHIROPRACTIC BILL.

The chiropractic bill failed to pass the last session of the Indiana legis-

lature. It is exceedingly fortunate that the bill was defeated, for never in the history of Indiana politics has a bill with more damaging possibilities been presented to our law-makers for consideration. The state already harbors within its border more pseudo-physicians and medical pretenders than we can well tolerate, and to legalize chiropractic, which is an offshoot of osteopathy, but without requiring any particular preparation for the work, would mean to let down the bars to a horde of charlatans who would impose on the sick and suffering to an extent unheard of before.

The absurdity of the scheme proposed by the chiropractors is evidenced by the statement made in the catalog of the so-called United College of Chiropractors of LaFayette, Ind., from this we quote as follows: "All that is needed to be successful in relieving all conditions due to spinal pressure is a knowledge of the spine and its relation to the various nerve trunks that leave the spinal cord through the foramen or opening in the spine. This knowledge can be acquired by anyone of average intelligence, under our methods of teaching, in a few weeks' time. . . . The chiropractor cures and relieves the afflicted by removing the pressure of the subluxation that causes the trouble. . . . The remuneration is just as you see fit to make it. You charge according to the success and the amount of business that you have. . . . Our short course can be completed in sixty days, and most students are ready by then to begin work in the field of disease and suffering. . . . Our single tuition is \$100, payable on beginning the study and lectures. The tuition price for man and wife is the same as for one, except that the wife will have to pay \$10 extra on graduation for diploma and graduation expense to the management. . . . At present, the requirements to enter a chiropractic college are a common school education, average intelligence and earnestness to learn and become a proficient chiropractor. . . . It is the purpose of this catalog to enable those who are wearing their lives out in menial positions to better themselves and become independent. . . . Let your creed be, 'I will learn chiropractic, as it is a congenial occupation. I will win as others have. Others have gained the glorious goal, so will I. I will increase my income and be independent.'"

Incidentally, it should be remembered that Dr. J. M. Hancock, the president and general manager of the United College of Chiropractors, in LaFayette, Ind., a school that makes chiropractors in sixty days, is no other than the quack who has appropriated the name of the "United Doctors," and incorporated the same in Indiana. For full information on this subject our readers are referred to the pamphlet entitled, "The United Doctors, Fake Specialists, Who Prey on the Sick and Defraud the Public," printed and distributed by the American Medical Association. It is fortunate that the legislature did not legalize the work of this crowd of fakers, for, as *The Journal A. M. A.*, says, "The success of these swindling concerns in making money depends on their use of the newspapers and the credulity of the people in accepting the false and fraudulent statements they make in their advertisements. When once the people know how they are defrauded and deceived in a matter so important as their health, and when they realize that the newspapers of their respective communities which they support are really partners in this cruel swindling game, they will call the newspapers to account, and the United Doctors and all other shameless medical frauds of this character will suddenly find themselves out of business."

The chiropractors are even worse than some of the medical fakers who have at least a semblance of medical education. The chiropractors attempt to treat all diseases with the hands, and without the use of drugs; and they learn this wonderful (?) plan of treatment in sixty days, and publicly announce that financial returns from the practice are handsome. With the legal recognition of the chiropractors would naturally come a demand for recognition on the Board of Medical Registration and Examination, with the inevitable lowering of the standard which we now have, for by creating a majority on the Board the representatives of the pseudomedical cults could eventually wipe out of existence the present high standard of medical requirements and make Indiana the laughing stock of the neighboring states where a broad and liberal medical and premedical education is required before a license is granted to treat the sick and suffering who deserve and should have the protection of the state from medical frauds.

It is needless to say that the Bill introduced in the Indiana Senate was promptly killed. At this writing no other state in the union has passed such asinine legislation. It seems their lawmakers are at least semi-intelligent.

—o—

THE ANNUAL MEETING OF THE STATE SOCIETY AT TOPEKA, MAY 7-8, IS GOING TO BE A CORKER. YOU CANNOT AFFORD TO MISS IT!

—o—

The following is a copy of House Bill No. 75, which became a law at the last session of the legislature.

In place of reading a comic weekly, try reading this, it is more humorous:

HOUSE BILL NO. 75.

An Act to authorize and regulate the practice of chiropractic, to provide for the licensing and examination of chiropractors, to create a state board of examination and registration to provide for the appointment of same, to provide a curriculum, and establish a standard of efficiency, to provide prerequisites and establish a fee for examination, to provide for the disposal of the fund arising from said fee, to regulate the holding of meetings of said board and issuance of license to practice chiropractic, to provide a penalty for practicing chiropractic without a license as provided by this act, and to repeal all acts and parts of acts in conflict herewith.

Be it enacted by the Legislature of the State of Kansas:

Section 1. That there is hereby created and established a board to be known by the style and name of the state board of chiropractic examiners, said board shall be composed of one ordained minister, one school teacher, and three (3) practicing chiropractors of integrity and ability, who shall be residents of the state of Kansas, and shall have practiced chiropractic continually in the state of Kansas for a period of not less than two (2) years. No two chiropractic members of said board shall be graduates from the same college of chiropractic.

Sec 2. The governor of the state of Kansas shall within thirty (30) days after the taking effect of this act, appoint three chiropractors who shall possess the qualifications, specified in section one of this act, to constitute the members of said board. Said members shall be so classified by the governor that the term of office of one shall expire in one year, one in two years and one in three years from the date of appointment. Annually thereafter the governor shall appoint one member who shall be licensed practitioner and possess the qualifications specified in section one of this act, to serve for a period of three years, and shall fill all vacancies in said board caused by death or otherwise as soon as possible.

Sec. 3. (a). Said board of chiropractic examiners shall convene within thirty days after their appointment and elect a president, a vice-president and a secretary-treasurer from their membership.

(b). Said board shall hold regular sessions, at such places as the board may decide; the first week in January, April June and October, respectively of each year, and shall publish such dates for examination and place of meeting in some newspaper of general circulation at least fifteen days prior to said meeting.

(c). Said board shall have authority to administer oaths, take affidavits, summon witnesses and take testimony as to matters pertaining to their duties. They shall adopt a seal which shall be affixed to all licenses issued by them and shall from time to time adopt such rules and regulations as they deem proper and necessary for the performance of their duties, and they shall adopt a schedule of minimum educational requirements, which shall be without prejudice, partiality or discrimination as to the different

schools of chiropractic. The secretary of said board shall keep a record of the proceedings of the board which shall at all times be open to public inspection. Said board shall also keep on file with the secretary of state a copy of their rules and regulations for public inspection, and shall elect annually a president, vice-president and a secretary-treasurer. A majority of the board shall constitute a quorum.

(d). A license to practice chiropractic within this state shall be issued to the individual members of said board at the first meeting of said board upon payment of the regular fee as provided for in this act.

Sec. 4. It shall be unlawful for any person to practice chiropractic in this state unless they shall have first obtained a license as provided in this act; provided, however, that nothing in this act shall apply to or effect any persons who are now actually engaged in the practice of such profession except as hereinafter provided.

Sec. 5. (a). Any person wishing the right to practice chiropractic in this state, before it shall be lawful for him to do so, shall make application to said state board of chiropractic examiners, upon such form thereof and in such manner as may be adopted and directed by the board at least fifteen (15) days prior to any meeting of said board. Each applicant shall be a graduate of a chartered chiropractic school or college which teaches a course of three years of six months each or more, requiring actual attendance in same. Application shall be in writing and shall be signed by the applicant in his own hand writing and shall be sworn to before some officer authorized to administer oaths, and shall recite the history of the applicant as to his educational advantages, his experience in matters pertaining to a knowledge of the care of the sick, how long he has studied chiropractic, under what teachers, what collateral branches, if any, he has studied, the length of time he has engaged in clinical practice; accompanying the same by reference therein, with any proof thereof in the shape of diplomas, certificates, etc., and shall accompany said application with satisfactory evidence of good character and reputation.

(b). There shall be paid to the secretary-treasurer of the state board of chiropractic examiners by each applicant for a license, a fee of \$15.00, ten dollars of which shall accompany application and the remainder \$5.00 shall be paid upon issuance of license. Like fees shall be paid for any subsequent examination and application.

Sec. 6. Examinations for license to practice chiropractic shall be made by said board according to the method deemed by it to be the most practicable and expeditious to test the applicant's qualifications. Such application shall be designated by a number instead of his or her name so that the identity will not be discovered or disclosed to the members of the board until after the examination papers are graded.

(b). All examinations shall be made in writing, the subjects of which shall be as follows: Anatomy, physiology, hygiene, symptomatology, nerve tracing, chiropractic, orthopedia, principles of chiropractic and adjusting as taught by chiropractic schools and colleges; provided, that applicants for license under this act shall be required to pass the same examinations in physiology, anatomy, hygiene and symptomatology required of licensed practitioners of medicine and surgery in this state. A license shall be granted to all applicants who shall correctly answer (75%) seventy-five per centum of all questions asked, and if any applicant shall fail to answer correctly sixty per centum (60%) of the questions on any branch of said examination he or she shall not be entitled to a license.

(c). Any chiropractor who has complied with the provisions of this act may adjust by hand any displaced tissue of any kind or nature, but shall not prescribe for or administer to any person any medicine or drugs now or hereafter included in materia medica perform any minor surgery, only as hereinbefore stated, nor practice obstetrics.

Sec. 7. All chiropractors practicing within this state six (6) months prior to the passage of this act shall be granted a license as herein provided, without examination, provided that application be made within sixty (60) days after the taking effect of this act and accompanied by the required fee as herein provided.

Sec. 8. (a). The state board of chiropractic examiners may refuse to

grant or may revoke a license to practice chiropractic in this state, or may cause a licentiate's name to be removed from the records in the office of the recorder of deeds in this state upon any of the following grounds, to wit: The employment of fraud or deception in applying for a license or in passing an examination provided for in this act; the practice of chiropractic under a false or assumed name; or the personation of another practitioner of like or different name; the conviction of a crime involving moral turpitude; habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate him or her for the performance of their professional duties. Any person who is a licentiate, or who is an applicant for a license to practice chiropractic against whom any of the foregoing grounds for revoking or refusing a license is presented to said board with a view of having the board revoke or refuse to grant a license, shall be furnished with a copy of the complaint, and shall have a hearing before said board in person or by attorney, and witnesses may be examined by said board respecting the guilt or innocence of said accused. (b). Said board may at any time within two years of the refusal or revocation or cancellation of registration under this section, by a majority vote, issue a new license or grant a license, to the person affected, restoring him to or conferring upon him all the rights and privileges of, and pertaining to the practice of chiropractic as defined and regulated by this act. Any person to whom such rights have been restored shall pay to the secretary-treasurer the sum of \$15.00 upon issuance of a new license.

Sec. 9. (a). Every person who shall receive a license from the state board of chiropractic examiners shall have it recorded in the office of the recorder of deeds of the county of which he resides and shall likewise have it recorded in the counties to which he shall subsequently remove for the purpose of practicing chiropractic. (b). The failure or refusal on the part of the holder of a license to have it recorded before he or she shall begin the practice of chiropractic in this state after having been notified by the state board of chiropractic examiners to do so, shall be sufficient grounds to revoke or cancel a license and render it null and void. The recorder shall keep for public inspection, in a book provided for that purpose, a complete list and description of the licenses recorded by him. When any such license shall be presented to him for record he shall stamp upon the face thereof his signed memorandum of the date when such license was presented for record.

Sec. 10. (a). All examination fees received by the state board of chiropractic examiners under this act shall be paid to the secretary-treasurer of said board who shall at the end of each year deposit the same with the state treasurer, and the said state treasurer shall place said money so received in a special fund of the state board of chiropractic examiners and shall pay the same out on warrants drawn by the auditor of the state thereof, upon vouchers issued and signed by the president and the secretary-treasurer of said board. Said moneys so received and placed in said fund may be used by the state board of chiropractic examiners in defraying their expenses in carrying out the provisions of this act. (b). The secretary-treasurer shall keep a true and accurate account of all funds received and all vouchers issued by the board; and on the first day of December of each year he shall file with the governor of the state a report of all receipts and disbursement and the proceedings of said board for the fiscal year.

The members of said board shall receive a per diem of ten (\$10) dollars per each day during which they shall be actually engaged in the discharge of their duties, and mileage at the rate of three (3) cents per mile for each mile necessarily traveled in going to and from any meeting of said board. (d). Such per diem and mileage and such other incidental expenses necessarily connected with said board shall be paid out of the fund of the state board of chiropractic examiners and not otherwise.

Sec 11. Chiropractic practitioners shall observe and be subject to all state and municipal regulations relating to the control of contagious and infectious diseases, sign death certificates and any and all matters pertaining to public health, reporting to the proper health officers the same as other practitioners.

Sec. 12. The treasurer of said board shall give bond in such sum and with such sureties as the board may deem proper. Upon sufficient proof

to the governor of the inability or misconduct of a member of the board, said member shall be dismissed and the governor shall appoint his successor from some licensed chiropractor practicing in this state who shall be a graduate of a different school than those represented on the board.

Sec. 13. Persons licensed to practice chiropractic under the laws of any other state having equal requirements of this act, may, in the discretion of the board, be issued a license to practice in this state without examination, upon payment of the fee of fifteen (\$15.00) dollars as herein provided.

Sec. 14. Any person who shall practice or attempt to practice chiropractic, or any person who shall buy, sell or fraudulently obtain any diploma or license to practice chiropractic, whether recorded or not, or who shall use the title chiropractor, D. C., Ph. C. or any word or title to induce belief that he is engaged in the practice of chiropractic without first complying with the provisions of this act, or any person who shall violate any of the provisions of this act shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not less than fifty (\$50.00) dollars nor more than two hundred (\$200.00) dollars or by imprisonment in the county jail for not less than thirty (30) days nor more than one year or both at the discretion of the court. All subsequent offenses shall be punished in like manner. Nothing in this act shall be construed to interfere with any other method or science of healing in this state.

Sec. 15. It shall be the duty of the several prosecuting or district attorneys of this state to prosecute all persons charged with the violation of any of the provisions of this act. It shall be the duty of the secretary-treasurer of said board, under the direction of said board to aid said attorneys of this state in the enforcement of this act.

Sec. 16. All acts and parts of acts so far as they are in conflict herewith are hereby repealed.

Sec. 17. This act shall take effect and be in force from and after its publication in the statute book.

—o—

SOCIETY NOTES.

3rd District, H. B. Caffey, councillor, Pittsburg:

The semi-annual meeting of the Southeast Kansas Medical Society was held at Parsons, April 2, under the presidency of Dr. Hugh B. Caffey. The following is the program:

1. President's Address, "Society Activities 3rd District," Dr. Hugh B. Caffey, Pittsburg.

2. Paper—Dr. E. E. Liggett, Oswego.

3. "A Method of Determining the Extent of Stricture of the Lower Bowel for the Purpose of Instituting Operative Procedure," Dr. J. M. Frankenburger, Kansas City, Mo.

4. "The Relation of the Pharangeal Lymphoid Ring to General Health," Dr. H. C. Markham, Parsons.

5. "Proprietary Medicines," Dr. G. A. Blasdall, Garnett.

6. Lecture with lantern slide illustrations, "The Gross and Microscopical Lesions of Syphilis," Dr. Frank Hall, Kansas City, Mo.

Dr. H. C. Markham of Parsons, gave a "Throat Clinic" and Surgical and Medical Clinics were held at Mercy Hospital.

After the evening session a banquet was tendered the society at the Hotel Mathewson by the Labette county society.

The regular meeting of the Montgomery County Medical Society was held at Coffeyville, Kansas, Friday, March 21, 1913.

The following program was given:

Clinical Cases.

Puerperal Sepsis—Its Conservative Management, Dr. W. R. Fisher.

"Why Weepest Thou?", Dr. Clifford P. Johnson.

—o—

4th District, W. E. McVey, councillor, Topeka:

The annual meeting of the Golden Belt Medical Society was held at Junction City, April 3rd. Following is the program:

"Injuries of the Spinal Cord Due to Accident," Dr. O. D. Walker, Salina.

"Extra-Uterine Pregnancy, With Report of Cases," Dr. George B. Norberg, Kansas City, Mo.

"Report of Cases, With Comments," Dr. R. C. Lowman, Kansas City, Kansas.

"Tuberculosis of the Kidneys," Dr. W. D. Storrs, Topeka.

Election of Officers.

L. O. NORDSTROM, Sec'y.

—o—

5th District, W. E. Currie, councillor, Sterling:

Program of the Harvey County Medical Society for April:

"MATERIA MEDICA AND THERAPEUTICS."

"The Iodides," Dr. S. S. Haury.

"Indications for Use of Strophanthus and Digitalis," Dr. B. A. Countryman.

"The Ammonia Salts," Dr. Max Miller.

Review of Recent Literature or Report of Case, Dr. L. T. Smith.

F. L. ABBEY, Sec'y.

—o—

ANNUAL MEETING OF THE STATE SOCIETY, TOPEKA,
MAY 7-8.

—o—

NEWS NOTES

DON'T FORGET ANNUAL MEETING AT TOPEKA, MAY
7-8.

—o—

The following state societies defend their members in suits for malpractice:

California, Illinois, Indiana, Iowa, Kansas, Kentucky, Mary-

land, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Vermont, West Virginia and Wisconsin.

—o—

The state board of Medical Examination and Registration will hold its next meeting at the National Hotel, Topeka, Kansas, June 10, 11, 12. Dr. H. A. Dykes of Lebanon is the secretary.

—o—

Dr. C. W. Cole of Norton was recently elected president of The Rock Island High Way Association, St. Joseph—Denver. It is an auto road extending through the northern tier of counties from St. Joseph west touching all county seats as far as Colby, where it joins the Golden Belt road from Kansas City to Denver.

—o—

Miss M. Edna Huff is the new superintendent of the Norton Cottage Hospital.

—o—

New Medical Society Organized.—The faculty and students of the University of Kansas Medical College, Rosedale, organized a medical society, February 21, with an initial membership of sixty and elected Dr. Arthur E. Hertzler, Kansas City, president, and Dr. C. A. Doty, secretary.

—o—

Dr. B. F. Slusher, Hutchinson, fell from his buggy recently, fracturing his forearm.

—o—

Dr. S. A. Bass, Wichita, fractured his right arm while cranking his automobile, March 7.

—o—

Dr. J. H. Guinn, Arkansas City, announces his intention of discontinuing practice and of removing to Long Beach, Calif.

—o—

Dr. W. L. Jacobus, Ottawa, was operated on for appendicitis in the University Hospital, Kansas City, recently.

—o—

OBITUARY.

James M. Gray, M. D., College of Physicians and Surgeons, Keokuk, Ia., 1883; Kansas City (Mo.) Medical College, 1893; died at his home in Hutchison, Kans., about January 7, aged 50.

—o—

Alfred G. Abdelal, M. D., University of Montpelier, France, 1852; a veteran of the Civil War and Franco-Prussian Wars; for many years a practitioner of Lawrence Kans., died at his home in Kansas City, Mo., January 25, from senile debility, aged 80.

George S. Liggett, M. D., Washington University, St. Louis, 1876; a member of the American Medical Association; died at his home in Oswego, Kans., January 11, aged 59.

James F. Robertson, M. D., Detroit (Mich.) Medical College, 1877; a member of the Kansas Medical Society; mayor of Caldwell, Kans., for one term; died at his home, March 5, as the result of injuries received in an automobile accident three months before, aged 57.

William C. McCurdy, M. D., University of Medicine, Indianapolis, Ind., 1898; physician and health officer of Pawnee County, Kans., and health officer of Larned; president of the Larned Hospital Association; died at his home, February 14, after an operation for kidney disease, aged 44.

Harvey Daniel Hill, M. D., University of Michigan, Ann Arbor, 1867; a veteran of the Civil War and later in charge of the government dispensary at Springfield, O; for three terms a member of the Kansas legislature from Butler County; died at his home in Baldwin, Kansas, February 8, aged 73.

William R. S. Cornell, M. D., University of Louisville, Ky., 1880; for a time teacher in the Joplin (Mo.) Medical College; died at his home in Paola, Kans., February 1, aged 63.

A. J. Scofield, M. D., Ensworth Medical College, St. Joseph, Mo., 1893; died at his home in Quenemo, Kans., February 10, aged 60.

Communications.

Editor Journal:

Have read and thoroughly digested Dr. J. C. Shaw's letter to the Kansas State Journal for March. I want to say that I am thoroughly in accord and sympathy with what he says. If there was ever a pernicious piece of legislation attempted upon the dispensing doctors of this state, this was one. It is high time that the medical profession of this state became thoroughly aroused to protect their interests.

It seems as though the poor benighted doctor cannot put into use prophylactic methods fast enough. He must be hedged about with restrictions for fear he might produce a tinnitus aurium by

giving an overdose of quinine, not as an emergency, but from his dispensary. But if this has the O. K. of the corner drug store, no such a condition would arise for your little two-by-four clerk might add a little hydrobomic acid, (at the suggestion of "Prof." Sayre.)

The point is this—when the medical profession of the great state of Kansas has to be dominated by the druggists, suggested by "Prof." Sayre; by one Englehard of Chicago; it is time to call a halt and bring some of these self-appointed dictators up with a jerk.

FRED CHANDLER, M. D., Bonner Springs.

—O—

Announcements.

Doctor James W. May, Kansas City, Kansas,

Dear Doctor—I am writing to call your attention to the reunion of the members of the Phi Beta Pi medical fraternity who reside in Kansas, to be held during our next state medical society meeting at Topeka. We expect to have a little dinner or supper together the first night of the meeting at one of the hotels. I would be glad to have you announce this in the next issue of the Journal. It is for all the alumni of this fraternity as well as for any active and honorary members who may live in the state or may be at this meeting. We expect to have a good reunion.

I will write you again as soon as the plans are definitely arranged so the hotel can be announced.

With best wishes, I am yours very truly,

LLOYD A. CLARY.

—O—

MISCELLANEOUS

Intelligence and Wealth.—The village of Greenwich, Conn., boasts fifty-seven millionaires. These millionaires have children and wives. The estates they own are valued at around \$10,000 per acre. It is perhaps the highest-priced suburban property in the world. Greenwich has also mosquitoes, and a special brand—anopheles. In consequence, last year this village had 900 cases of malaria. Some of these probably meant neurasthenia or other ills for the rest of their victims' lives. There is no finer foundation for chronic invalidism. In this epidemic, for such it was, were included the children and the wives of the rich. Malaria is not, like tuberculosis and many other maladies, a luxury of the

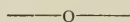
poor. Nor is it a filth disease. It has one, and only one, cause; the anopheles mosquito. This discovery is now twelve or fifteen years old. No educated physician in the world any longer questions it. Panama is the everlasting monument to this discovery. But for this discovery we should have failed in building the canal, as the French failed, and for the same reason; anopheles. With all this in mind (the regular health officer having done nothing), one or two intelligent physicians of Greenwich asked the town committee for an extermination fund—\$5,400. The committee refused. Then the fifty-seven millionaires were appealed to and they royally subscribed \$280.—Collier's Weekly.

Loyalty.—Loyalty should be a predominant trait in the character of all those living in a free country. No organization can survive in these days of keen competition and do the things that result in its wisest usefulness unless its members are loyal. This is certainly true of the county society. What shall be said in defense of those members who have what standing they possess as physicians and surgeons because of the existence of an organized profession, and who at the same time go about criticising the county society, the state society and the American Medical Association, simply because they have some pet idea of their own that has not as yet been adopted by these organizations. If we accept membership in the county society let's be loyal to it. Why put time and money into it and then go around and tell anyone who will listen to us that the organization is obsolete and is not meeting the needs of doctors generally. Don't let's tear down until we can build better. Let's stand by the only thing that we now possess that helps us keep the position we now have, or gives promise of leading the fight for things that are soon to come. Rocky roads are ahead for us all. The organizations we have will accomplish things that no man or set of men can accomplish working alone.—Bulletin, Butler County (Ohio) Medical Society, February, 1913.

How About the Girl?—We wish to make the declaration of advocating the doctor's right to protect a woman, by giving her, her father, or some adult in her family, information of her fiancé's condition, if he be afflicted with any venereal disease. If a man deliberately announces his intention to marry while suffering from one of the venereal diseases, refusing to heed professional admonition not to do so, it becomes the moral duty of his medical attendant to give warning to the girl or some member of her family.

If an antiquated code is to stand in the way of saving an innocent young woman from a lifetime of woe and possibly a premature death—let us consign it to perdition. All codes regulating our conduct should be based upon common sense and one that is not should quickly be cast aside. The legal phase of this question should not give us any concern, for we need not describe in detail the man's condition—we need not violate the letter of the faith he has reposed in us, and even if we violate both the spirit and the letter, the end justifies. None else but the name and reputation of the patient is at stake and what are these when held up against the future health and happiness of a young trusting woman?

Our women and our country—let's guard them both.—
American Journal Dermatology.



CONTENTMENT.

Other Doctors all seem busy,
You are loafing on your couch?
Never mind, your day is coming—
Get a grin on, cut the Grouch!

Is he dashing like the devil
Past your silent office door?
Let him go, he's welcome to it!
Your day is coming, don't get sore!

That man's got his list of patients,
Folks who tried him, found him true;
When they're ill they all stick to him,
Just as your folks stick to you.

It often happens in your practice
That for weeks your rest is slim,
Patients all get sick together;
That's the way it is with him.

Then there comes a lull in business,
For a time the work is ended;
Else how could your tired body
Get the rest that God intended?

How could you do ALL the business
In the town, and 'round about?
Be thankful for the other doctors,
Be glad they're here to Help You Out!

So when the others all are busy,
And you're loafing on your couch,
Think of what you'll do next winter—
Get a grin on! Cut the Grouch.

—Pennsylvania Medical Journal.

—o—

CLINICAL NOTES

Gynecological Hints.—Before making a physical examination of the patient the outer clothing and corset should be removed while she is in a sitting posture on the table. The heart and lungs should be first examined. She should lie on her back with the knees flexed on the abdomen. All bands should be loosened and the abdomen thoroughly examined. This thorough examination of the chest and abdomen will in many instances determine whether or not an operation should be performed on the genital organs.

A highly padded table covered with a clean sheet is much better than an examining chair; and infinitely better than a bed for purposes of examination.

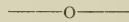
For an ordinary examination very few instruments are required. A medium sized bivalve speculum, a small and medium sized Sims' speculum, a Sims' depressor, and long dressing forceps are the instruments most frequently used. For a thorough exploration of the urethra, interior of the bladder and uterus, special instruments are required and only the expert will learn anything from their use.

It is very important to differentiate between a carbuncle and a protrusion, or, more strictly speaking, a prolapse of the urethral mucosa from the meatus uriniarius. In the former condition thorough anesthesia of the affected part with a 2 per cent. solution of cocaine and the application of a fine ligature will bring about a cure. On the other hand, if this method of treatment were resorted to in a case of prolapse, the condition would be rendered worse. Delicate plastic surgery with the patient under general narcosis is necessary for its cure.

Vulvitis and vaginitis are almost invariably associated, and if the former is cured the latter will usually disappear.

In a few instances vulvitis is due to parasites, or other external irritants, and when the cause is removed the disease will vanish.—Ralph Waldo, International Journal Surgery.

The Treatment of Acute Suppurative Tenosynovitis of the Finger.—From *Infections of the Hand*, published by Lea and Febiger, Philadelphia.—Kanavel, in discussing the treatment of acute tenosynovitis of the finger states that very commonly, when a finger is infected, it is some days before the tendon sheath becomes involved; again, it may be early, and when it is invaded the symptoms develop rapidly, because, as was mentioned above, there is so little resistance that the infection spreads throughout the sheath in a short time. However, during the preliminary stage, much may be done to prevent a spread into the sheath. The best sort of application is undoubtedly some form of moist, hot dressing. Boric acid solution in saturated strength is most commonly used, but any of the other solutions in common use are probably just as efficient. Carbolic acid dressing in any form should be avoided because of the danger of gangrene. Local painting with ichthyol, iodine, and such irritating solutions is absolutely useless. German surgeons speak highly of 95 per cent alcohol dressings left on twenty-four hours. There probably are no more efficient than the hot boric solution, and are always a source of some anxiety, owing to the possible danger of their catching fire, as the author has personal knowledge of in one case. Probably the next most essential procedure is to keep the part at rest; this, of course, is indicated in any infection, since the muscular action tends to disseminate the germs, thus extending the area to be walled off by the leukocytes carried in by the dilatation of the vessels incident to the hot dressings. Elevation of the part is recommended by many, but personally I could never see any advantage in it, except to make the arm comfortable, and it is true the elevation of the hand is sometimes necessary for this. If the infection is severe, put the patient in bed. An ice bag in the axilla may help some. Keep the bowels open and the kidneys active. Preserve the nutrition of the patient. The methods of Bier and Klapp are discussed above.



Beware of a Full Bladder.—As long as the possibility of the full bladder is not definitely excluded great caution should be exercised in making and especially in expressing a diagnosis. A distended bladder may be a great wrecker of reputations.—Arthur E. Giles in *Clinical Journal*.

THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, MAY. 1913.

No. 5

PRESIDENT'S ADDRESS.

DR. GEO. M. GRAY, Kansas City, Kansas.

Annual Meeting Kansas State Medical Society, Topeka, May 7, 1913.

I wish first to express my appreciation for the very great honor you have conferred upon me in selecting me as your President. To be selected as your presiding officer is an honor that will make me forever deeply grateful to the members of the Kansas Medical Society.

In casting about for a theme to present to you at this time, it seems to me that it would be best to select one that might interest as far as possible, the general practitioner as well as the surgeon and I have therefore decided to take as my subject, Nephro-colo-ptosis. A condition that often is unrecognized or the symptoms attributed to some intra-abdominal inflammation, as appendicitis or salpingitis and operation suggested, when a more careful examination would have avoided an error which caused the sacrifice of the appendix and possibly the tubes and ovaries without securing any relief from the symptoms of which the patient complained. These cases are far too common and after undergoing several operations generally the appendix being removed, without relief. After this, then an ovary and tube. Still the pain persists and adhesions are suggested as the cause and the abdomen is again opened and adhesions sought for. Still there is no relief and the patient is put down as a neurasthenic. When the discomfort and pain complained of was due to a movable kidney with ptosis of the ascending colon and caecum or to a mobile caecum without ptosis of the kidney.

It certainly has been the experience of every surgeon that a long, freely movable and quite normal appendix has been removed on the diagnosis of chronic or recurrent appendicitis. In-

deed, the suspected offending organ may be normal in every particular. They are the cases without the history of acute and febrile attacks and in which the predominant features are evanescent colicky attacks, ill defined gas pains in the lower right quadrant of the abdomen and constipation, with the endless train of nervous symptoms always present in this condition.

These operations are remembered as easy ones, because the caecum although perhaps at first not readily found because the ascending or transverse colon would get in the way, but could, when found be easily drawn into the wound together with a good part of the ascending colon. They are the record making operations for appendicitis.

It is not alone in the multipara that this condition is found but in young girls and adolescents of both sexes. The actual condition, ptosis of a mobile caecum and in not a few cases the caecum is enormously distended and perhaps veiled by vascular adhesions and bands, which extend over the caecum and onto the appendix and ileum and in a few cases may cause kinks which give rise to colicky pains.

Dr. Coffey, in an article on gastro-intestinal stasis in Surgery, Gynecology and Obstetrics, says that observers have noted that a large number of otherwise normal individuals have a movable right kidney.

It has been stated and is probably true that a unilateral movable right kidney is almost never seen, except in cases where there has been a deficient peritoneal fusion of the ascending colon and mesocolon with the parietal peritoneum in front of the kidney and that after examination of a large number of cases when he had the abdomen open that he had not observed a single unilateral movable right kidney where a proper rotation and peritoneal fusion had taken place. Incomplete fusion in the left side is not so serious owing to the costo-colic and gastro-splenic ligaments, which form two very firm additional supports and thus prevent the descending colon from prolapsing and dragging down with it the left kidney. In fact, a floating left kidney without a corresponding right movable kidney is rarely ever seen. Both kidneys being down indicates a general visceral ptosis.

The floating kidney in the past has been considered a primary trouble. The facts as they develop seem to indicate that it is only an incident to the incomplete peritoneal fusion and subsequent dragging down by an insufficiently supported large intestine. This fully accounts for the fact that the operation for floating kidney has been in the past in many instances a dismal

failure. The caecum being a very heavy organ and serving as a reservoir for most of the fluids of the intestinal tract, has a great tendency to prolapse. In certain cases the hepatic flexure remains very firmly fixed to the kidney and duodenum and the kidney remains in place in which case the caecum may become elongated and its weight pulling on the fixed point, produces an acute flexion at the hepatic flexion, thus greatly increasing the constipation.

In some instances the appendix and its mesentery has become adherent to the parietal peritoneum and thus becomes a ligament. Many times in such cases the appendix has been removed at a previous operation and as a result the caecum has gone lower than before and the patient has not been at all benefited and in some instances his condition has even been made worse.

Lane has also called our attention to the fact that in some of these cases of right-sided ptosis the mesentery of the ileum a few inches from the ileo-caecal valve is shortened and as the caecum prolapses the ileum also becomes a ligament helping to hold the mobile caecum from this fixed point. He claims that this produces a short kink which causes stasis in the small intestine.

In considering nephro-colo-ptosis I think we are justified and the subject is best handled by making three divisions of the abdomen, e. g., right sided ptosis, midline ptosis and left abdominal ptosis.

In right abdominal ptosis we have the right kidney, ascending colon and caecum to consider. In the midline the stomach and transverse colon. In left abdominal ptosis, the left kidney and descending colon. Left abdominal ptosis is so rare in fact, never found except where all of the abdominal viscera are down. (Glenards' Disease.)

Etiology and diagnosis of nephro-colo-ptosis. A great deal has been written of late on this subject and my paper must be largely a review of the work done along this line by such men as Rovsing, Wilms, Klose, Longyear and Coffey. There has been much discussion as to the nature and cause of abdominal ptosis. The medical men taking the ground that in most cases, ptosis is due to malnutrition, corset and tight lacing. Neurologists, that it is due to a central nervous condition. Orthopedic men, that body malnutrition is the principal cause. Arbuthnot Lane, that the assumption of the erect posture of man, especially modern man, has overtaxed the peritoneal supports of the abdominal organs, causing certain portions of the alimentary tract to sag down lower than others with formation of adhesions which produce

kinks in the intestines, resulting in stasis and absorption, poisoning the system, destroying nutrition causing absorption of fat, thus letting down the organs. Wilms, Klose and others hold that a mobile caecum is the principal cause of intestinal stasis. While all of these are probably factors to some degree in bringing about these ptoses, yet there is behind all this, a faulty development in the way of imperfect fusion of the intra-abdominal supports, that must be conceded to be the prime factor in all of these cases. This is especially to be noted in the mobile caecum, where the layers of the meso-colon have failed to fuse, thus weakening the support.

Longyear says: "The perfect construction of a well designed machine requires that it shall be so made as to perform its work properly and at the same time to continuously do its work for a reasonable time without breaking down or getting out of order. That these purposes may be fulfilled the first requisite that the designer insists on is that the material used shall be of the quality best adopted to the use of the various parts of the mechanism, an imperfectly tempered springs results in imperfect working of the machine, if not in utter failure.

The human body may be compared to a well designed machine, but it must be constructed according to specific requirements in order to enable it to perform its given work in a perfect manner. The function of the various parts must be performed in harmony and the purely mechanical parts must operate without friction or failure and not break or yield when subjected to the normal strains of the working machine. While this human machine has been well designed, its construction is not always in accordance with its requirements and the results are naturally variable. One will succumb to the first strain. Some vital part in such an instance having inherited tissues too frail to do its work. Lack of structural integrity may be marked in the purely mechanical parts, those which have to do with the binding together of different parts of the sustaining tissues.

It would appear therefore, that the causes of displacement of internal organs are passive and active, the former being the primary or fundamental etiologic factor, and the latter the secondary or contributory causes, and cases illustrating this in family tendencies are numerous. We are all familiar with cases where whole families are neurotic suffering with visceral ptosis of abdominal organs, some with ptosis of the stomach, others with a loose kidney or retroverted uterus, and all due to some defect in development of the mechanical supports of the organs. It does

not seem reasonable that the small weight of the kidney alone is sufficient to cause its displacement, even when loosely secured and we have known for a long time that ptosis of the right kidney is always associated with ptosis of the ascending colon, but did not recognize the significance of this condition until H.W. Longyear pointed out the connection that existed between the ascending colon and the right kidney through the nephro-colic ligament which he has shown to be the most important factor in ptosis of the right kidney by exerting a constant downward pull on the kidney in coloptosis.

His investigation by radiography has shown coloptosis present in all of a large number of cases of nephro-ptosis and he asserts that the presence and action of the nephro-colic ligament makes it the most important factor in connection with the secondary or contributory causes as by it the prolapsing colon pulls the kidney out of place and he asserts that the laxity of the peritoneal attachment of the colon at the hepatic flexure is the key to the line of right sided ptosis. When this gives way the caecum and ascending colon drop and the drag on the kidney through the nephro-colic ligament begins and that the right kidney does or does not descend, in accordance with the laxity and length of the nephro-colic ligament. The caecum, consisting of a sac with its out-let upward and receiving contents of the small intestine forced into it, must lift this up over the hepatic flexion of the colon, we can readily see that considerable downward traction is constantly put upon the fixed points of support to the caecum and ascending colon, and where to this is added the weight of a full torped caecum the tendency to pull down the right kidney exerted through the nephro-colic ligament is quite plausible.

On the left side the action of the colon is quite in the opposite direction, thus exerting no countertraction on the left kidney through its nephro-colic ligament. Hence the left kidney is very rarely dislodged from its bed.

Symptomatology—The symptoms caused by ptosis of the caecum, colon, stomach and right kidney are so complex and their manifestations so varied that these patients are often treated for all manner of ailments which do not exist and to receive all sorts of opinions as to the cause of their ailment. As is well illustrated by the following case:

Mrs. Silverneal, a patient on whom I operated and Miss Bender, another case illustrating the manner in which these cases are generally disposed of and reported later in this paper.

Longyear says of the symptoms of nephro-colo-ptosis the

first symptoms are not those referable to the kidney but are symptoms referable to the stomach or colon. Because of the traction on the duodenum with resultant angulation of the bowel and interference with the function of the biliary and pancreatic ducts, gastric manifestations will be the most likely to be the first in evidence and a superficial diagnosis made of indigestion or biliousness. The symptoms are distress after eating referred to the right epigastric region, gas, occasional nausea and vomiting. The complexion becomes muddy or there may be slight jaundice. There is loss of flesh and a general appearance of malnutrition. Concurrently with the gastric manifestations there will occur symptoms referable to the colon, caused by its angulations and sacculations and stasis of gas and fecal matter. Pain is usually complained of at the points of flexion and assume at times a severe colicky character.

The difficulty experienced by the caecum in evacuating its contents frequently causes severe pain with spastic contraction of the gut which is sometimes so severe as to resemble peritonitis or appendicitis as in case No. 3 and No. 4. Here the diagnosis of peritonitis had been made in Case No. 3 and on opening the abdomen no evidence of a former attack of peritonitis was found, but a sacculated caecum lying well down in the pelvis resting against the uterus was present and undoubtedly the cause of the pain and distress she had complained of.

Case No. 4, a young man, farmer by occupation, with a diagnosis of chronic appendicitis, revealed a normal appendix except for pericolic bands which extended over the appendix which was posterior to the caecum and entirely buried by the web-like membrane; here the caecum was well down in the pelvis, sacculated and covered by pericolic membrane. In this case and also in Case No. 3, the right kidney was not loosened as the nephrocolic ligament was long and the pull on the kidney not sufficient to dislodge it.

Toxemia resulting from stasis of the colonic contents was well marked in both of these cases. These cases of visceral ptosis manifest nervous symptoms of various kinds and degrees of severity such as frequent attacks of headache, vertigo, hysteria in various forms, tachycardia, insomnia, loss of memory and mental inability and often especially in cases of long standing a condition of neurasthenia that may lead to the most extensive disorders of the nervous system.

Symptoms referable to a loose kidney, Dietl's crisis, constitutes the most severe and marked symptom in floating kidney.

It was present in case No. 1 and 2, well marked and diagnosed as appendicitis in both cases. A careful history in these cases would have prevented this error. In each case, the attack of pain always comes on in the evening, ushered in with severe epigastric pain, nausea and vomiting, pain relieved by the recurrent posture for one to two days, and not accompanied by fever. A count of the white blood cells especially of the poly-nuclear cells would be of great value in such cases if there is any doubt, as the white cells would not be increased in Dietls' crisis and would be in any acute infective processes such as appendicitis or colocystitis. A floating kidney of the most extreme character may exist for years without the occurrence of this accident and without any pronounced symptoms referable to the kidney. The symptoms being those due to the dropped caecum, and in the other cases the crisis may be very mild, and last but a very short time.

Differential Diagnosis—Pain is the most constant symptom in nephroptosis, nephro-colo-ptosis and coloptosis. Colbat in his work on differential diagnosis states that constipation is more often the cause of abdominal pain than all other conditions combined. Constipation is a most constant symptom in coloptosis. The most important pathological condition and the one generally confused with visceral ptosis is appendicitis. It is the most important by reason of the relative frequency of its occurrence and because of the fact that the increasing familiarity with its manifestations leads to eager and often unwarranted incomplete and erroneous diagnostic conclusions. Pain and sensitiveness alone at McBurney's point, are not sufficient to warrant a diagnosis of chronic appendicitis. A mobile caecum or ascending colon distending by reason of angulation at some point will cause symptoms which simulate sub-acute appendicitis which, if you add to this nausea and vomiting, with a febrile condition a very careful investigation is required as colonic stasis accompanied by intestinal toxemia may be the cause of it. Absence of muscular rigidity with the "board like" feel of the right side of the abdomen is of value when distinguishing between appendicitis and coloptosis. But the blood count will probably give the most positive evidence and be of the greatest value, especially the differential count, as this will probably not be increased in nephroptosis or coloptosis, and would be in any acute infection such as appendicitis or colocystitis. The radiograph if taken with the patient in the upright position, twelve or fourteen hours after a bismuth meal would show the caecum distended and in the pelvis. I think a very accurate idea may be obtained as to the position of the

colon or caecum by percussion and palpation of the abdomen, especially with the patient in the standing position.

Ocular inspection of the abdomen is of great importance as the shape of the abdomen gives positive and valuable information as to probable visceral ptosis. This is especially of value in the multipara with lax abdominal muscles. In virginal ptosis the muscular relaxation is not so marked but the contracted upper abdomen with full and bulging lower abdomen is quite significant and a diagnosis of chronic appendicitis should never be made without a most thorough examination of the abdomen by inspection and palpation in the recumbent and standing position.

The effect body position may have in relieving the pain or in producing it is a valuable symptom, e. g., appendicitis, colocystitis or any of the infectious process in the abdomen will not be relieved by assuming the recumbent position for a few hours. Neither will it appear after the individual has been on the feet for some hours. A person who suffers with Dietls' crisis is rarely attacked at night, but generally in the afternoon after being on the feet for several hours. Nearly all of these patients suffering with pain due to ptosis of the colon or kidney will as a rule discover that their pain and discomfort is relieved by assuming the recumbent position. This is very constant in nephro-ptosis. Quite common in coloptosis and coupled with the pronounced nervous symptoms, among which the most common and constant is headache, insomnia, loss of memory and mental inability make the case of one suffering from intestinal toxemia due to coloptosis unmistakable.

Treatment—The treatment of these cases naturally divides itself into pallative and curative. The condition to be overcome is mechanical and any treatment to be of any permanent benefit must overcome or rearrange a mechanical defect. The operation for fixing the floating kidney as it has been done in the past has naturally failed of relieving the patient of the symptoms complained of. While the floating kidney has been cured from an anatomical standpoint and when attacks of Dietls' crisis were among the symptoms complained of this has probably been relieved by preventing the twisting of the kidney pedicle, but this only relieves a small part of the symptoms complained of, the digestive and nervous symptoms continue and the nephroptosis of the past have only had a tendency to discredit surgery.

The treatment to be adopted in any case of nephrocoloptosis will depend, naturally, upon the stage the case has reached, and the symptoms presented. Many surgeons hesitate in recommend-

ing operations for the relief of coloptosis for the reason that surgical treatment either fails altogether in producing relief or it often introduces other conditions incidentally which in themselves cause abdominal conditions worse than those from which relief is sought. Rovsing who advocates direct gastropexy regards the dropping of the stomach as the most important factor in producing the pain and nervous symptoms, constipation, etc. The stomach may be supported in one of three ways, by direct fixation of the stomach wall to the abdominal wall (gastropexy.) Second, by basting together and shortening the lesser omentum as proposed by Stengel Beyea. Third, by supporting the stomach from below by suturing the great omentum directly to the abdominal wall as proposed by Coffey of Portland. The operation proposed by Dr. Coffey would have the advantage over the first two in that it supported the transverse colon and the stomach as by a hammock, and in not fixing the stomach directly to the abdominal wall. I have performed the Coffey operation in quite a number of cases with varying results, but on the whole with improvement in the cases.

It would seem to me that no one operation can fit all of these cases of visceral ptosis as no two cases, are just alike where the transverse colon is down so is the stomach, and when the right kidney has descended so has the ascending colon and caecum, and not infrequently both exist and one operation as gastropexy or plication or suspension cannot as I see relieve the condition. Dr. Longyear would rely upon fixing the kidney and raising the caecum and ascending colon by the operation he has described, which consists in drawing up the colon and kidney by use of the nephrocolic ligament through a lumbar incision. We know that a dropped stomach may exist and give no symptoms, but such is not the case where the caecum and colon are down. The stomach may be dropped to a marked degree and yet perform its function perfectly, and gastropsis where the stomach is performing its function perfectly required no correction of position. The stomach and transverse colon are found below the level that is generally considered normal, in at least half of the abdomens that we open for other causes. The caecum being down always gives symptoms due to weight and stasis and in this condition the appendix is always found posterior to the caecum.

Lane is the advocate of the most radical measure for the relief of this condition in removal of a large portion of the colon and anastomosis of the ileum with the sigmoid.

We see cases but they are rare, where this operation would

be the only means for relief but the operation is not popular and but rarely indicated in this part of the country, as the habits of Americans are active and intestinal stasis as seen by Lane is rare in this country. Dr. Longyear's operation where a single operation is to be advised I think, will do more to relieve the constipation and the pain and dismal discomfort than any of the several operations advised, and is accompanied by the least risk of life. Rovsing makes two distinct classes in treating his cases, viz., virginal ptosis and maternal ptosis. This seems to me to be wise, as the symptoms met with in the virgin are quite distinct and differ materially from those seen in women who have borne many children and have relaxed and flabby abdominal muscles, which are distinctly the cause of the ptosis. Women suffering from the coloptosis who have never borne children with a very much less degree of ptosis as a rule suffer much more from the nervous symptoms than those who have ptosis as a result of muscular relaxation, with maternal ptosis the constipation and consequent intestinal stasis with all of its consequences is the dominant feature.

Mechanical supports in the way of abdominal supports, corsets and trusses are as a rule disappointing. I am convinced that if any appliance is to be used for this purpose that the truss with a well padded abdominal piece, and heavy steel springs is to be preferred, and must be so constructed that the individual can adjust it easily in the recumbent position.

Case 1—L. S., married, thirty-two years old, mother of one child eight years old, residence in Kansas City, Kansas.

Family History—Father and mother both dead. Cause or age not stated. Has had the usual diseases of childhood.

Personal History—For a few months before birth of baby, had pain in region of gall-bladder. This disappeared after birth of baby, but there remained a tender spot, but was well until about fourteen months ago, when present trouble began with constant distress in right upper quadrant of abdomen, especially while sitting down, and seemed to get relief by standing erect. Later abdomen would become distended with gas. At times had sharp cutting pains extending from right costal margin to right shoulder blade. These attacks of pain would last for few hours, then subside for a few days or weeks, but was never entirely free from the distress in right upper quadrant of abdomen. These attacks of pain were often so severe as to be compelled to call a physician for relief of pain. She had been told that these attacks were due to appendicitis. Her bowels were generally constipated. No urinary symptoms. Does not sleep well. Appetite poor. Is

nauseated occasionally but never vomits. Says pain in the left side has been as troublesome as on the right side since December, 1908. Examination: Slender and somewhat sallow complected woman, but not jaundiced. First examined at my office. Right kidney palpable and distinctly movable. Inspection of abdomen standing shows marked fullness in umbilical region and sinking in from umbilicus to lower end of sternum. Marked tenderness complained of from McBurney point to costal border but decided tenderness when pressure is created on the kidney. Splashing sound is elicited upon shaking abdomen from side to side in umbilical region. Temperature normal and pulse 80. Between the time I first examined her and the second examination there was an interval of six months and one week before last examination which was June 1st, she had had a distinct attack of Dietl's crisis, followed by passage of large quantity of urine. She was admitted to St. Margaret's hospital on June 6th and operation for fixation of the movable kidney performed on June 7th, 1909. After fixation of the kidney, the abdomen was opened by incision in right semi-lunar line for purpose of examination of intra-abdominal condition. The appendix and caecum were brought out of the wound, and appendix found to be healthy but was removed as there was some controversy as to whether she had appendicitis or not. Gall bladder was explored and found free from concretions and healthy. Stomach was distinctly prolapsed and could be easily pulled into wound below umbilicus transverse colon was resting below brim of pelvis. The fixation of the kidney has been followed by marked relief of pain and her condition has been fairly comfortable since operation, though it has been necessary for her to take medicine to keep the bowels regular, and for abdominal support she wears a straight front corset which gives marked relief in supporting the stomach.

Case No. 2—Miss Jessie B., age 27 years, United States school teacher, single, Nowata, Oklahoma.

Complaint—Pain in right side of abdomen, continuous and present all the time. At times this pain is more severe and occasionally accompanied by nausea and vomiting.

Family History—Father living and well. Mother living and well. No brothers or sisters. Collateral history negative to T. B. malignancy or insanity.

Personal History—Began to menstruate at 14 years of age, always regular, 28 day type, painless duration 4-5 days until last year. Last year has had some dysmenorrhea, but not severe. Coffee for breakfast and occasionally drinks tea.

Previous Illness—Measles at five years. Whooping cough and mumps when young. Has tonsilitis about three times a year.

Present Illness—Patient says that her present illness dates back to seven years ago. One evening she came home and ate a large dish of strawberries for her dinner. The next morning she was nauseated and vomited, developed a severe pain in epigastrium but does not remember whether pain preceded vomiting or not. Later pain was localized to right side of abdomen, extending from right costal margin to pelvis. Pain was present for about three weeks and severe for about two days. After the first few hours was always localized to right side of abdomen. Has had many attacks of pain during the years following the first illness but none so severe as the first one until three months ago. At this time the pain was confined principally to the right side of abdomen. Since this attack has never been free from pain in right abdomen. Up until about three months ago, patient was always constipated. Lately she has noticed that her constipation is followed by diarrhea which lasts two or three days. For last three months has had painful urination, but no change in frequency or quantity. Pain is frequently relieved by lying in a horizontal position frequently when in a lying posture gets relief by flexing her legs on abdomen. Walking or standing for any length of time brings on attacks. Running a sewing machine especially precipitates attacks. For several months has had gas and a fullness in stomach.

Physical Examination—Inspection of body reveals a slender, narrow chest, upper abdomen contracted, lower abdomen full, skin slightly jaundiced. Palpation of abdomen reveals very loose and movable right kidney, (in recumbent posture.) Percussion of abdomen indicates cecum is very low, stomach below umbilicus. Vaginal examination reveals a normal position of uterus, no marked disease of appendages, no marked rigidity of abdominal muscles or especial tenderness in region of appendix. Patient had been referred to me by her family physician with diagnosis of appendicitis, although all of her attacks of pain had been in the afternoon and when severe were relieved by remaining in bed for one or two days. Her attacks were clear Dietls' crisis and due to the loose kidney. Yet this was only the cause for a part of the discomfort of which she complained. The constant dragging pain in the right lower quadrant of the abdomen, the constipation alternating with diarrhea, the vomiting and nausea were in a measure due to the ptosis of the colon and stomach.

MOBILE CAECUM

Case No. 3—Mrs. Minnie Timberlake, 19, single; American, housework. Camden Point, Mo.

Complaint—Cramp like pains in pelvis, more severe on right side. Sometimes accompanied by vomiting.

Family History—Father living, 60 years of age; troubled with some kind of chronic cough. Mother living and well. One brother living and well. One brother dead in infancy. Five sisters living and well. Two sisters dead in infancy.

Collateral—History of T. B. and malignancy negative. As a result of some brain trouble when three years old, one brother's mind is affected.

Personal History—Began to menstruate at thirteen. Has always been irregular and has always had dysmenorrhea. For two years after menstruation began and until she was fifteen years old, she would occasionally go beyond her menstrual time, sometimes two to three weeks, during these two years menses never lasted more than three or four days, but were always accompanied by pain. About three years ago had tonsilitis and was in bed five weeks. At the same time had a felon on her thumb. Averaging about three times a year since she had her attack of tonsilitis she has gone as long as two months without menstruations. Two or three times the interval between her periods was only two weeks. The duration of the flow is not increased. For past two years pain accompanying menses has been getting worse. Has not menstruated for six months. Has had a leucorrhoea for several months. Has had cramping pain in pelvis for two months. Attacks last for two or three days and occur about two or three times a month. Has pain on both sides of pelvis more severe on right. Pain is similar to that she had when menstruating, but more severe. During the last six months attacks of pain have always been accompanied by vomiting. Last September had one of these cramping spells and following was in bed for three months most of the time. Physicians said she had peritonitis. She was very nervous and complained of a continuous burning sensation in her pelvis. Constipated all the time during these three months and often vomited. Took considerable medicine at the time and believes this had something to do with the vomiting. During these three months complained of occipital and right temporal headache and a pain in lumbar region. Is troubled at times with palpitation of heart and insomnia. Bowels always constipated. She says she thinks she has been jaundiced. She says she has noticed recently that there is some tenderness along right costal margin.

Blood—Leucocytes, 10400. Polyneuclears, 69%. Small 20%. Large 6%.

Examination—Patient slender individual, upper abdomen narrow, lower abdomen full, right kidney palpable but not very movable. Caecum is low, lying well down in the pelvis. Stomach is somewhat low but not extreme ptosis.

Vaginal Examination—Reveals normal uterus as to size and position; no disease of appendages. This patient was referred to me with a diagnosis of appendicitis. Yet there was no indication in the history to warrant the diagnosis, nor could we concur in the diagnosis after examination of patient but we regarded the case as one of mobile caecum with intestinal stasis. After the abdomen was opened the caecum was found lying in the pelvis against the bladder and uterus; appendix posterior, but not diseased.

MALE MOBILE CAECUM.

Case No. 4—Frank Dawling, age 28 years, American, single, farmer; Atchison, Kansas. Admitted March 18th, 1913.

Complaint—Pain in right lower quadrant of abdomen, sometimes pain in lumbar region, more marked in right lumbar region.

Family History—Father living and well. Mother living and well. Two brothers dead. One in infancy and one accident. One sister dead in infancy. One sister living and well.

Collateral—No history of T. B., malignancy or nervous trouble.

Personal—Moderate user of tobacco and alcoholic drinks.

Previous History—Measles three years ago. Chicken pox when young.

Present Illness—About two years ago, two hours after heavy lifting on a building felt a severe pain in right and left lumbar regions, more severe in right. Pain was severe for three days. Ten days after had pain in right lower quadrant of abdomen. Pain has been present most of time for last two years, but never has been severe. Has never vomited or had chills during attacks of pain. Has been constipated all his life but worse since accident two years ago.

Diagnosis—Mobile Caecum.

Operation—Appendectomy. Caecum sutured to posterior abdominal wall.

Operated March 18th. Discharged on April 8th, 1913.

Case No. 5—Mrs. Mary Yeardsley, 29, U. S., married, 1305 S. 35th St., Argentine, Kansas. Housewife.

Complaint—Extremely nervous. Nervousness came on sud-

denly one year and nine months ago. At this time she had a very sick baby and had been sitting up nights for several weeks. Was perfectly well and healthy up to that time. At that time had a nervous seizure. Did not at that time and has never since lost consciousness. Has had several attacks since which were not so severe. For last two years has had trouble with her stomach. Left side bloats. Has dull pains and a sense of weight and oppression in epigastrium. Is always dizzy and usually has a headache. Complains of a vague pain in pelvis, lumbar region and left thigh. Sense of weight and oppression and bearing down pains in the pelvis.

Is constipated all the time except when she has these spells, at which time she has a diarrhea. Has to take cathartics practically all of the time. When nervous has to urinate frequently. Urination at times is very painful and burning.

Menstrual History—Began to menstruate at 19. Has always been absolutely regular every 28 days, and always entirely free from pain.

Child Birth.—Has five children all living. One born when 23. One born when 25. One born when 26. One born when 27. One born when 28.

Has never had any miscarriages. Labors were all normal. Has always been up in ten days. No fever following any except the last. In bed six weeks after birth of last child with chills and fever. Had her uterus scraped.

Previous Illness—Measles, mumps, malaria, chicken-pox, typhoid fever, pneumonia. Has had leucorrhea one year.

Family History—Father dead, cancer of the face. Mother dead, typhoid fever. One sister living and well.

Physical Examination—Patient very nervous and excited. Fairly well developed and nourished. When standing epigastrium contracted. Lower abdomen full and pendulous. Habitus enteropticus marked.

Lungs negative to percussion and auscultation. Respiratory mobility good and equal. Respiratory murmur normal.

Heart negative to percussion and auscultation. Apex beat, 1 inch inside nipple line, 5th interspace. No adventitious sounds.

Abdominal—No abdominal tenderness or rigidity of muscles. Liver and spleen not palpable. Right kidney freely movable. Left kidney not palpable.

Stomach on inflation is two inches below umbilicus and extends three inches to right of median line.

Vaginal Examination—Uterus freely movable in normal position. No tenderness on either side.

Muscular reflexes present and exaggerated. Eyes react readily to light and accommodation.

Laboratory Findings—Blood: 90%. Reds 5,200,000. Leucocytes 8,800. Polynuclears 46%. Small lymphocytes 48%. Large lymphocytes 6%.

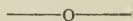
Urine—1024 clear, acid, no albumen, no sugar. Indican in abundance. Microscopically negative.

Diagnosis—Floating right kidney. Gastropsis. Mobile caecum.

Operation—Reno-colic ligament shortened.

Convalescence—Excellent.

April 30, 1913, patient discharged well as far as the kidney is concerned. I was unable to palpate the kidney in any position on left side back or standing. Have supporter applied for support to stomach.



TABES DORSALIS AND ALLIED STATES: THREE CLINICAL CASES.

A. L. SKOOG, M. D.

Associate Professor Nervous and Mental Diseases, University of Kansas; Neurologist to Bell Memorial, St. Margaret's and Swedish Hospitals, Kansas City.

Cases and Discussion Presented Before Wyandotte County Medical Society, April 29, 1913

Tabes dorsalis is of particular interest to not only those engaged in the special practice of neurology, but also to the general practitioner, the surgeon, ophthalmologist, otologist and other specialists. The importance of having some knowledge concerning the diagnosis of the disease is emphasized by the frequent neglect to diagnose the disease in its incipency or the earlier stages which is all important to the patient, since we know the law is pretty well established that neurons in the spinal cord once destroyed can never be revived. Errors of diagnosis in the early stages frequently come to my notice. Only four days ago a patient was referred to me for diagnosis who had had definite symptoms of tabes for at least six years. He had never had any pain excepting in the left arm which had been present for three or four years. These pains led him to a surgeon in Nebraska where a neurectomy of the ulnar nerve above the elbow joint was performed, the diagnosis then being a chronic neuritis. It is needless

to add that the operation did not afford the results promised. The three cases seated before you includes one frank, almost classical case of tabes; one case of tabes complicated with a recent stroke and following hemiplegia; and one which might be classed as pseudo-tabes, but really a case of cord sclerosis of a mixed type.

Case 1. L. L. This man has been a patient in the neurological department of the dispensary of the University of Kansas for some time. His age is 48. Born in Sweden. Was a bartender for twelve years and subsequently a laborer. He has not been able to do any hard work for several years. He states that his wife is well. One child died of "cramps" at age of one month. He has one son age 16 and well. One daughter age 14, had chorea three years ago and is now "nervous." Family history negative. His complaint was pain in the back and legs and frequent urinary incontinence. He had "brain fever" at age 14. He contracted a chancre twenty years ago for which he was given some treatment.

Present Illness—The first symptom was sharp pain in the calves of legs and tendon Achilles fifteen years ago. The pains were lightening-like and often of considerable severity. At first they occurred only when walking. These grew worse with time and were of longer duration, in later years occurring when quiet as well as when taking physical exercise. He has had more or less trouble with urinary incontinence for six years. Loss of sexual power has been present six years. Dizziness and a roaring in the head has existed for five years. He has been "weak and tired" for several years. He states that he has lost much weight. He has not had any sensory disturbances until very recently when there has been present a peculiar numb feeling in both lower extremities. When walking he feels as if he were stepping on cushions. Spots have appeared floating before his eyes.

Examination—The man appears anemic. A loss of weight and power is apparent. Abdominal and chest findings are negative. The radial, temporal and retinal arteries do not indicate any definite arteriosclerosis. The mental state is normal. His vision is fairly good. The pupils are irregular in outline. The ophthalmoscope findings are normal except slightly hazy borders of the discs. The right pupil is of about normal size and the left myotic. Light reaction is completely absent. Accomodation is present but a little diminished. The balance of the cranial nerves are normal. His gait with eyes open is good. There is a small amount of Rombergism present. There is also a little ataxia present in the upper extremities. The deep reflexes in the upper extremities are normal. The patellar and Achilles reflexes

are completely abolished. There is a slight analgesia present in the lower extremities. Deep sensation is much diminished. Bone conduction to tuning fork vibrations is diminished.

0.9 grams neosalvarsan was given intravenously in 300 c. c. normal saline solution five weeks ago. In one hour 50 c. c. of blood was removed, and the serum allowed to separate. At the end of 48 hours the serum was inactivated, and 37 c. c. of a 40% dilution introduced into the spinal canal after first having withdrawn 40 c. c. of cerebrospinal fluid. In 10 days this procedure was repeated. He has been almost free from the tabetic pains since the treatments. An examination of the cerebrospinal fluid removed showed a lymphocytosis of 35 per cu. m. m. It gave a decidedly positive Wassermann reaction. There was greatly increased globulin.

This patient illustrates an almost classical case of tabes. There is not as much ataxia and Rombergism as is present in the average case at this stage.

Case 2. McG. The man is from St. Margaret's Hospital, where he has been treated during the last six weeks. Age, 52. Single. Laborer. His habits for some years have been irregular. Alcohol has been used in excess. Had syphilis in 1904 which was inadequately treated. For several years has had sharp pains in the lower extremities. The individual pains were sudden in their onset, severe, of very short duration, radiating downward for some distance and recurring. They were classically tabetic. These pains have also been present in the arms during the past year or two. Three years ago ataxia appeared in the lower extremities. He was unable to walk as well in the dark as formerly. Has had some trouble with micturition during the past year. The patient entered St. Margaret's Hospital March 19th on account of a left hemiplegia. He was unable to move the left arm and leg. The left face was involved. Speech was much impaired. He gives a history of having felt well and working hard on March 17th. On the following day he had to quit work one hour earlier than usual on account of "dizziness." At five P. M. he noticed a weakness in left leg and arm and some awkwardness in speech. He slept well all night, but in the morning when attempting to rise he fell. He became weaker toward noon and could not move without help. Consciousness was not disturbed.

Examination—The patient on entering the hospital had normal mentality. Articulation was so much disturbed that it was difficult to understand him, representing a motor disturbance. The pupils were equal and not contracted. Light reflexes were

absent. Accommodation was present. The extrinsic ocular muscles were normal. The left face showed a mild palsy. The right arm and leg had fairly good power. He had almost no use of the left arm. The left fingers could not be moved. Some motion was present in the left leg. There was a little ataxia in the right arm. The ataxia was much greater in the right leg than in the arm. The deep reflexes in the upper right extremity were sluggish. They were slightly increased in the left. The patellar and Achilles reflexes were completely abolished. No Babinski, Oppenheim or allied phenomena could be obtained. All forms of sensation were decreased on left side, more so in the lower extremities than in the upper. Deep sensation in the right leg was diminished, other forms normal. During the past six weeks of observation the patient has had more or less urinary incontinence. It has improved considerably lately. His condition has steadily improved until now he is able to walk with the support of a cane, although with some difficulty. He can elevate his left hand to the head. There has been no change in the reflexes. Lumbar puncture revealed cerebrospinal fluid under 80 m. m. pressure, water gauge. 15 c. c. were removed. It contained 32 lymphocytes per cu. m m., using the Fuchs-Rosenthal counting chamber. The butyric acid and Nonne-Apelt tests were decidedly positive indicating a marked increase in globulin. The Wassermann reaction, using the cerebrospinal fluid, was markedly positive.

This case is peculiarly interesting in that we undoubtedly had existing in the patient tabes for some years, and that only about six weeks ago a stroke occurred caused by a vascular lesion in one of the branches of the right cerebral artery. We believe that the lesion was a thrombosis resulting from an endarteritis obliterans. More or less encephalomalacia ensued consequent upon the deficient blood supply to the internal capsule and neighboring central cerebral ganglia. The grave involvement of the motor portion of the right internal capsule accounts for the severe hemiplegia of the opposite side of the body. A partial involvement of the sensory portion of the internal capsule explains the incomplete left hemianalgesia and hemianesthesia. These vascular changes in the brain might be classed as a parasymphilitic disease, the same as tabes. I wish to call your attention particularly to the interesting fact that the deep reflexes in the hemiplegic lower extremity continued to remain abolished after the cerebral insult. Had the patient not had a previously existing tabes these reflexes would have been greatly exaggerated with probably an ankle and patellar clonus.

Case 3. P. J. Patient has been at St. Margaret's Hospital

about four months where he is now an orderly. Age 57, single. Complaint, weakness in the lower extremities and pain in the abdomen and legs. Family negative.

Past History—Patient is the son of an Irish merchant. During the past twenty years he has led a nomadic life. Much time has been spent in railroad camps, perhaps frequently in unhygienic surroundings. He admits having used alcohol in excess at times. Admits having had gonorrhoea several years ago. Denies lues. Had typhoid five years ago. An appendectomy was performed nine years ago.

Present Illness—About six years ago there was noticed an unsteadiness in lower extremities, especially when climbing a ladder. He had a sense of fear of falling. This was followed by a sense of weakness in lower extremities, right greater than left. About three years ago he had some trouble in walking, especially down-stairs. Dizzy sensations have been present for one year. This was increased at night or with closed eyes. He has experienced some diplopia. During the past few months he has had lightening-like pains commencing in the abdomen and radiating down the extremities. They were of short duration and frequently recurring. He has had a girdle sensation at the nipple region. There has been a loss in weight. No urinary trouble was present. Headaches were present a few years ago but none recently.

Examination—Heart, lungs and abdomen negative. There is present a pupillary myosis, light equaling the left. Outline of pupils is regular. The pupillary right reflexes are sluggish with fairly good range. The ophthalmoscope shows normal discs. There is a slight impairment of hearing, right equals left. The protruded tongue is slightly tremulous. Motor power in the lower extremities is diminished, the right leg being weaker than the left. The same is true to a lesser degree in the hand. His gait is slow, unsteady and ataxic. He has much difficulty in turning rapidly, with a tendency to fall to the right. A marked Rombergism is present. Ataxia is present in both the upper and lower extremities. There is present a marked dysdiadococinesia, right greater than left. There is a tendency to an intention tremor. He has no trouble with writing or speech. The abdominal reflexes are diminished. All the deep reflexes are slightly increased, about equal on the two sides. There was present a mild and questionable Babinsky on the right side. An area of hyperesthesia in the region of the fifth and sixth dorsal cord segments was present. Lumbar puncture revealed a normal clear fluid. It was not under increased pressure. There was no pleocytosis. No abnormal

elements in the fluid. The butyric acid test, Nonne-Apelt, and Wassermann were negative. In a differential diagnosis of this case we have considered tabes, paresis, multiple sclerosis, spastic paraplegia and mixed sclerosis. Against tabes might be mentioned the increased deep reflexes otherwise there would be a close clinical resemblance. However, there are a few exceptional cases of tabes with increased deep reflexes. The cerebrospinal fluid findings are entirely against tabes or any other parasymphilitic disease. Thus paresis can be ruled out. There are not enough symptoms for multiple sclerosis and the age of the patient practically eliminates its consideration. Spastic paraplegia does not include an accounting for all the symptoms. The diagnosis is a mixed sclerosis of the spinal cord and involving the cerebral axis. We believe the cause to be an endogenous intoxication of the central nervous system of a chronic type. Alcohol and perverted metabolism combined are probably responsible. Heilbrunner has given much on the pathology of these conditions, especially with the Nissel and Weigert-Pal stains has he shown various types of degeneration of the nerve elements. Nonne has compared the severe anemias with certain alcoholic degenerations of the central nervous system, and for the latter has used the term "myelitis intrafunicularis."

CONCLUSIONS.

Many interesting facts might be discussed in connection with these cases. Time will permit of only a brief consideration of a few important and pertinent facts.

Why do we have the Westphal phenomenon or absence of the patellar reflexes in tabes? The deep reflexes are altered or lost in more than 96% of cases of tabes. It is possible that a severe or complete degeneration of the posterior roots, spinal ganglia, or even nerve trunks might be the cause. It has been demonstrated that most of the cases in which the Westphal symptom was present have been caused by the destruction of the reflex arcs passing from the root zone entrance across the gray substance of the anterior horn cells. In tabes these fibres are apparently among the earliest to degenerate. Why the occurrence of the Argyl-Robertson pupil? There is an alteration in the reflexes in tabes in a high percentage of the cases. In a goodly number there still remains a trace of the light reflex in one or both pupils. For a number of years the theory was held that the symptom was produced by involvement of the cervical portion of the spinal cord, and that in this region there existed special tracts for the conduction of light reflexes. In recent years it has been shown by several re-

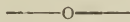
search workers, among them Mariana and Bach, that this reflex is lost or diminished owing to destruction or damage to the ciliary ganglion. It is interesting to note that in several of the autopsied cases studied, the light reflex was present on one side and absent on the other. In all of these cases it was demonstrated that the ciliary ganglion nerve cells continued to be present on the same side in which there was present a light reflex, and that the cells were destroyed in the ciliary ganglion corresponding to the side in which the light reflex was absent. I have recently studied in the University of Kansas' pathological department, a case of tabes whose death occurred in a late stage. Argyll-Robertson pupils had existed for some time. I could not find the left ciliary ganglion. I removed the right and made Nissel and Van-Gieson stains. No ganglia cells could be found.

In the majority of instances patients come to us seeking relief for the pains. The pains are usually relieved to a certain extent by a long period of absolute quiet or rest in bed. The coal-tar products and salicylates are valuable in combating this pain. Pyramidon is highly recommended and I have often found it of much value. One should hesitate in using opium or any of its derivatives on account of the danger of habit formation.

In view of the established fact that tabes belongs to the parasymphilitic group which includes as well paresis, many of the idiopathic optic atrophies, some progressive muscular atrophies, and certain arteriosclerotic diseases of the brain, the question arises as to the value of the specifics in the treatment of tabes. It has recently been shown by Noguchi that the spirocheta pallida can be demonstrated in the central nervous tissues of some cases of tabes and paresis. If so we might expect results from mercury, salvarsan or neosalvarsan. However, the results from the use of these drugs have not been very encouraging. It is quite possible that some cases of tabes and possibly other metasyphilitic diseases have a continued development of the spirochetes or tertiary luetic activities. It is possible that the cases reported with beneficial results from specific treatment, come under this class. When the splendid reports from the use of salvarsan appeared it was thought that possibly good results could be obtained in parasymphilitic conditions. Disappointment was evidenced early. At the Rockefeller Institute, Swift and Ellis (N. Y. Med. Jour., July 13, 1912), utilized a new method. It consisted of giving neosalvarsan or salvarsan intravenously. In one hour the blood is withdrawn under aseptic conditions. The serum is separated from the fibrin and corpuscles. At the end of 48 hours this clear serum is inactivated

at 57 degrees centigrade for 30 minutes, diluted to 40% with normal saline solution, and from 20 to 40 c. c. of this is injected into the lumbosacral cistern after withdrawing a goodly quantity of the cerebrospinal fluid. If possible, one should withdraw an equal quantity or more of the cerebrospinal fluid compared with the quantity of serum intended to be injected. The treated serum should be injected slowly through the same needle used for withdrawing the cerebrospinal fluid. Within thirty minutes after the injection intense pain appears in the lower extremities and trunk. It is necessary to resort to opiates to partially relieve this pain which continues for 12 to 48 hours. Several repetitions of this treatment should be resorted to after intervals of a few weeks.

I have now given this special treatment eleven times to six patients, all well defined cases of tabes with more or less severe pains or crises. The first case had been suffering for some weeks with severe rectal cirses and uncontrollable diarrhoea. The crises and diarrhoea were promptly checked and did not recur. This patient was on the charity service at Bell Memorial Hospital, Rosedale. I have had relief or complete abatement of the pains in all of the cases where the treatment has been given. It is not believed that this treatment will restore any destroyed neurons. What occurs is probably a subsidence of the active or inflammatory process.



Crinoline gauze provides a better body for plaster bandages than soft gauze. The plaster should be spread evenly into the meshes.

To be most serviceable a plaster bandage should be very loosely rolled. It may be kept air-tight in gutta-percha sealed with chloroform.

In preparing the radial artery for transfusion it adds much to the simplicity of the procedure to dissect out the two venal comites en masse with the artery, separating the latter from the former only at the terminal inch (for cuffing). This little variation of the procedure vastly reduces the amount of handling which the artery receives, and provides a means of tying its minute branches at a distance from it, for both of which reasons the production of clotting in the artery by the dissection is obviated.—American Journal Surgery.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,

EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

Kansas is the only state in the Union which has legalized chiropractics. Isn't this fine reading?

—o—

Statistics have shown that almost 50 per cent of the source of suits for malpractice originate in fracture cases. Therefore, it would certainly seem wise in handling this class of cases to fortify yourself with consultation and not forgetting X-ray examinations whenever possible.

—o—

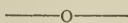
It is time to be planning the trip to Minneapolis for the A. M. A. meeting June 17-20th. And it also might be mentioned that if said trip is contemplated hotel reservations should be made without delay. Chicago, as large as it is and with as many hotels as it has, accommodations were hard to find after the session opened.

There will be many features, chief of which will be the side trips, mention of which will be made in the June issue. There will be an abundance of clinics held by prominent men from different parts of the country at the various hospitals in Minneapolis, St. Paul and at the Mayo's in Rochester. Clinics will not be held during the meeting, Tuesday, Wednesday and Thursday and Friday morning. This trip would certainly make a fine vacation and a profitable one.

The following from Collier's Weekly April 12, 1913 sent to the Journal by councillor Dr. Fee, says a great deal. It is indeed refreshing and withal very encouraging to have a lay magazine of this character do so much for the cause of humanity. Collier's magazine has performed a great service and we of the medical profession are able to realize it. To Collier's we again give our thanks for what you have done for the cause. Here is the clipping:

Chiropractic Spondylotherapy! This classic mouthful of syllables appears at the top of a card issued by a Detroit "doctor." It scans like poetry. It has a rise and fall of sound at once brisk and noble. It could be set to ragtime and sung trippingly. But its meaning is scarcely up to its meter, since it is the ingeniously invented name of the newest form of medical malpractice. "A Drugless Science which removes the cause of disease," its exploiters call it, and on this basis they conduct two fake colleges in Michigan. Manipulation of the spine is its alpha omega. All human ills, according to its creed, arise from a distorted spinal column. The wart on your nose and the corn on your toe are alike referable to an erring backbone. The chiropractor juggles your joints, and thereby cures you of the following troubles:

Paralysis, Deafness, Loss of Voice, Lumbago, Catarrh, Gallstones, Overweight, Rheumatism, Appendicitis, Neuralgia, Neurasthenia, Eye, Ear, Throat, Lung, Stomach, Liver, Heart Disorders, Diabetes, Bronchitis, Asthma, La Grippe, Dropsy, Eczema, Goiter, Fevers, Epilepsy, Insanity, St. Vitus's Dance, Kidney and Bladder Troubles, etc., all Cancers, Tumors, etc. That, considering the all-embracing "etc.," is a fairly comprehensive claim. One might well suppose that our old friend, Liquezone, had sprung into activity and print again. In the pamphlet issued by this cult, the term "Chiropractic" is duly explained as a "combination of two Greek words, meaning to do by hand." Spondylotherapy is not explicated in the text; but, summoning up all our classic lore, we hazard a guess that it derives from the Greek root which has given us that expressive, if inelegant, term, "spondulics," the love of which is said to be the root of all evil, and from "therapy" the science of healing or relief. Hence it would appear, etymologically, that a Spondylotherapie Chiropractor is a gentleman who, with expert hand, relieves you of your surplus cash painlessly while you wait. Meantime the colleges flourish and turn out their regular crop of quacks under the easy laws of Michigan.



Here is some food for thought. Something that will do no

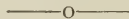
harm, on which to ponder. Something that might set legislators and even Governors to thinking. This editorial from the Journal of the American Medical Association speaks volumes:

DOCTORS IN TIMES OF PERIL.

During the recent period of disaster and havoc ordinary events were relegated to the back pages of the newspapers. Every issue of the dailies was full of heartrending and pathetic stories of disasters, storms and floods. The people responded to the call for help with the magnanimity and promptness which characterize the nation. From the scenes of the disaster came the call for food, clothing and shelter. But before this there came a call for physicians to minister to the wounded the sick, and the dying. From almost every afflicted locality soon came the same statement, "A special train carrying volunteer physicians, nurses, dressings and medical supplies is on the way to the scene of disaster."

So it is after every great calamity. The first men on the scene are physicians, performing their sacred work of saving life and relieving the suffering. This happens so constantly as to be an accepted occurrence. No one expresses any surprise. On the contrary, surprise would be aroused only if the nearest available physicians even failed to respond in numbers equal to the need. Leaving their own work, volunteering without hesitation for the hardest service, they toil often for days and nights without intermission, without asking for or expecting compensation. Instances are not hard to find. Following the recent cyclone in Omaha, our correspondent writes: "I have personal knowledge of physicians whose homes were destroyed, yet the moment they knew their families were not injured they left them and worked all night, ministering to the maimed and dying." There never has been a public calamity in which the services of physicians were not instantly offered, without money and without price.

At such times what becomes of the innumerable sects and cults which, under ordinary conditions, are constantly trying to usurp the place of the scientific medical profession and undermine the confidence of the public? Apparently they sink into obscurity and silence. When the emergency arises, what have they to offer? Suppose the dispatch from Ohio last week had read: "A Special train containing one hundred osteopaths is on the way to Dayton. All of the sufferers will be given spinal adjustments as soon as the train arrives." Or "It is reported that two hundred people are dead and thousands rendered homeless and in danger of their lives through exposure due to the floods in Columbus. A special train containing one hundred chiropractics is being sent to the scene at once. Those suffering from injury and exposure will be given immediate treatment for nerve impingement." Or let us even suppose that those who disdain all material methods should emerge from their state of self-absorption long enough to do something practical: "Senator Works telegraphs that he has arranged for a special train, containing one hundred Christian Science healers, to be sent to Omaha. This train has been given the right of way over all railroads. All persons injured in the cyclone and the blizzard will be given medical treatment as soon as the train arrives." No such items have appeared in any of the newspapers. They would be greeted with laughter from all over the country. The peculiarity common to all of the unscientific and irrational cults and fads is that, in times of real peril and need, they have nothing to offer. When lives are in danger and when death rides on the wind and waters, the people want the men of scientific training and experience, of cool judgment and steady nerves, who can carry to them all the aid the human intellect in its centuries of struggles has been able to discover. Fads and isms may be followed by some of our people in times of peace and safety, but they fail when real danger threatens.



The New Owen Bill—Senator Owen has introduced a revised bill providing for a national Department of Health. The new bill goes back to the original plan and provides for a Department of

Health with a secretary in the cabinet. It is by far the best measure which has yet been presented on this subject. It contains all of the strong points of preceding bills without any of the objections to which previous bills were subject. The return to a plan for a Department of Health is commendable. In the United States Public Health Service we already have a strong, efficient and rapidly developing bureau. In order to justify itself to the friends of advanced health legislation, any proposed change must provide for something larger, better and stronger than the existing health machinery. The movement for a department has gained strength enormously during the past three years. The opposition to it has crystallized in a constantly diminishing group of objectors, while public support for such a measure has been growing as its object and purposes have been better understood. The silly objections which were at first raised against the measure have been completely met. The establishment of a national Department of Health will not and cannot create a "medical trust." It cannot interfere with the rights of any citizen or with the authority of any state. It cannot have anything to do with the individual treatment of disease or with the administration of drugs. These facts have been proved repeatedly to the satisfaction of all those who really wish to know the truth. The only objectors left are those who are too ignorant to be able to understand, too fanatical to desire to understand, or too mercenary to care for anything except the possibility of interference with their private gains. The educational value of the efforts that have been made in the past are well worth the cost. The Journal of the American Medical Association thinks that the prospects for the passage of Senator Owen's bill are more favorable now than ever before.

—o—

Larned, Kansas, April 21, 1913.

Editor Kansas Medical Journal,

Dear Sir—Replying to yours of a few weeks ago, I wish to state that I requested our representative Mr. A. A. Doerr, to write us a short article along lines that he might select, but especially his ideas of our present Board of Health and the work being done. The enclosed letter speaks for itself. And right here I wish to say that the proper way to get proper legislation is to send proper men to the legislature. There is no man who stands so close to an individual as that man's family physician. A little time spent in the preliminary education of the men who go to Topeka, to make our laws, is worth more than a dozen lobbyists working overtime.

Put it in a personal way. Make your representative the champion of your cause, and he will make a strong effort to deliver the goods. Forget political affiliations and vote for the man who is in sympathy with the methods you espouse. Here in Pawnee county we in the medical profession feel we have made no mistake in sending Hon. A. A. Doerr to represent us at Topeka.

Yours truly,

J. A. DILLON, Councillor.

March 28, 1913.

Dr. J. A. Dillon, Larned, Kansas:

Dear Doctor—In reply to your inquiry as to the most feasible method to pursue, by lobby or otherwise, to secure the enactment of laws; the better enforcement of rules and to aid in the growth and development of the State Board of Health.

That the Board was beset with many tribulations during the past session, cannot be denied, and yet, some of the measures passed, of which the Board was the author, embody very advanced thought on these questions. From my observation as a member of the past legislature, I wish to say that public sentiment is a powerful factor and a great deal of feeling expressed during the past session concerning the "State Board of Health" was but the expression of public opinion.

The Board lays down its rules and quietly compels all parties at interest to live up to them. If conditions in communities are intolerably bad, perhaps an arrest is made. The fine is quietly paid. But the public—the people—are none the wiser. It, perhaps, has only been whispered to one or two that the state has been at work in town. The hundreds of safeguards which this department throws around the "Public" that it may be protected from all classes that would profit at the expense of public health are not at all understood by the people. The board has been entirely too modest. It has not kept the public in absolute confidence as to its own activity. It tries as much as possible to shield those from publicity whom it compels to comply with its rulings.

On the other hand, those who violated its rules and were brought under the influence of its cleansing power appealed at once to the populace at large, inferring that the board was a bunch of meddlesome doctors without any business capacity or experience, who were attempting to lay down silly rules for grown up people to follow.

And even members of the legislature had heard but little else concerning the activities of the board.

Public sentiment is the bulwark behind every law-enforcing power and the people should know of the great value the State Board of Health has been to them by compelling violators of our sanitary laws and pure food laws to conform and comply with the rules of the state board. The general public, today, knows principally about the drinking-cups and mosquito bar over the fruit baskets. But, of the vast amount of real service rendered it, they are truly uninformed, and the members of the past legislature reflected in a measure, this lack of understanding.

I do not think that the maintainance of a lobby at the legislature is of any consequence in questions that are commonplace and easily understood. A few active men among the membership of the legislature can accomplish a great deal more than outside influences. But, it is vitally important that the people of the state be given far more knowledge of the great and unselfish activity in their behalf and the vast good accomplished by the state board of health and its various departments.

Give me for a lobby an enlightened citizenship upon the question at issue and I care not what other influences are at work. That branch of the state activity will not be injured when is thoroughly understood; and to be fully appreciated it must be thoroughly understood by the people.

Yours respectfully,

A. A. DOERR, Representative 91 District.

—o—

NOTES OF THE TOPEKA MEETING.

The 47th annual meeting was a hummer in more ways than one.

—o—

The registered attendance was exactly two-hundred and eighty.

—o—

The weather was clear, and cool and all that could be asked.

—o—

The proceedings of the annual meeting will be published in full in the June issue.

—o—

The annual meeting of the society will be held next year at Wichita.

—o—

The symposium on Medical Legislation did not bring out much discussion, owing to the lack of time and the haste to get through with the program.

The entertainment Committee composed of members of the Shawnee County Medical Society was much in evidence, in fact the members and guests could not ask for greater courtesies.

Drs. Geo. M. Gray and J. T. Axtell will represent the society as delegates to the A. M. A., at Minneapolis in June.

The presidents' address which appears in this issue was a masterful effort. It was presented with case reports and skiagraphs which increased its value. It was well received.

The Defense Committee reported the successful defense of seven suits against members for alleged malpractice. None were lost. Certainly a fine record.

All things considered this was the best meeting the society has ever held. The program committee (consisting of Dr. Chas. Huffman) deserves special praise. It was the most even balanced scientific and interesting program ever given.

Representative Hall, in the Capitol, where the Scientific sessions were held seemed to be in good trim for the meeting. Heretofore the acoustic properties seemed to be very poor, but at this time there was no trouble in hearing the essayists.

The entertainments consisted of a luncheon at the Throop, extended by the Commercial Club of Topeka. At this function Dr. Petty-John extended a cordial welcome which was followed by an address by Dr. S. L. Brooking of Paola, the title of which was "A Toast to the Doctor."

On Wednesday evening the guests were entertained at Representative Hall by the Washburn Glee Club, who gave a highly interesting program.

On Thursday evening there was a luncheon and clinics tendered the society at the state hospital. This was given by Dr. Biddle the superintendent and the courtesy of the Governor and the Board of Control.

The exhibitors were few. Sophian-Hall-Alexander Laboratories being the most interesting. Others were: Physicians Supply Co., Hettinger Bros., Horlicks' Malted Milk Co., Victor Elec-

tric Co., Dr. W. H. Graves representing Lippincott's and C. V. Mosby medical books.

—o—

The following officers were elected for the ensuing year:

President, M. F. Jarrett, Fort Scott; 1st vice-president, C. C. Nesselrode, Kansas City; 2nd vice-president, J. F. Gsell, Wichita; 3rd vice-president, G. A. Blasdell, Garnett; treasurer L. H. Munn, Topeka, (re-elected); the secretary held over from last year.

The only change in the makeup of the Council was the election of D. R. Stoner of Quinter in place of E. J. Beckner.

—o—

The following is a copy of House Bill No. 313, which became a law at the last session of the legislature. This is the bill to which Hon. Geo. H. Hodges Governor, affixed his signature of approval:

HOUSE BILL NO. 313.

An act concerning the practice of osteopathy, creating a state board of osteopathic examination and registration, providing penalties for the violation of any of the provisions of this act, amending sections 8087, 8088, 8090, 8091 and 8093 of the General Statutes of the state of Kansas of 1909, and section 8089 of the General Statutes of the state of Kansas of 1909, as amended by chapter 297 of the Session Laws of the state of Kansas of 1911, and repealing said original sections 8087, 8088, 8090, 8091 and 8093 of the General Statutes of the state of Kansas of 1909, and section 1 of chapter 297 of the Session Laws of the state of Kansas of 1911.
Be it enacted by the Legislature of the State of Kansas:

Section 1. That there is hereby created a state board of osteopathic examination and registration consisting of five members who shall be appointed as follows: Within thirty days after this act goes into effect the governor shall appoint five persons who are reputable practitioners of osteopathy, and who are graduates of a reputable school or college of osteopathy, selected from a number of not less than fifteen to be recommended by the Kansas State Osteopathic Association, who shall have been in actual practice in the state of Kansas for at least three years. No member of the board shall be in any manner financially interested in or connected with the faculty or management of an osteopathic school or college. The term of office of the members of such board shall be designated by the governor and the term of one member shall expire each year. Thereafter in each year the governor shall in like manner appoint one person to fill the vacancy thus created in the board at that time from a number of not less than five who are recommended by the State Osteopathic Association, the term of said appointee to be for the term of five years. Any vacancy shall be filled by the governor for the unexpired term in the same manner as last above stated. The board shall, within thirty days after its appointment by the governor, meet in the city of Topeka and organize by electing a president, secretary and treasurer, each to serve for one year. Thereafter the election of such officers shall occur annually in February of each year. Each member of the board shall take and subscribe to oath prescribed by law for state officers, which oath shall be filed with the secretary of state. The secretary and treasurer shall each give bond, approved by the board for the faithful performance of their respective duties, in such sum as the board may from time to time determine. The board shall have a common seal, and shall formulate and adopt all necessary rules, regulations and by-laws, and the presiding officer and secretary shall be empowered to administer oaths. The board shall meet in the city of Topeka, at the call of the president, in the month of the election of its officers and in June of each succeeding year, and at such other times and places as a majority of the board

may designate. Three members of the board shall constitute a quorum, but no certificate to practice osteopathy shall be granted on an affirmative vote of less than three. The board shall keep a record of its proceedings and a register of all applicants for certificates, giving the name and location of the institution granting the applicant the degree of doctor of, or diploma in osteopathy, the date of his diploma, and also, whether the applicant was rejected, on certificate granted. The record and register shall be prima facie evidence of all matters recorded therein.

Sec. 2. Any person not now a registered osteopathic physician of this state, before engaging in the practice of osteopathy in this state shall make application to the board of osteopathic examination and registration, on a form prescribed by the board, for a certificate to practice osteopathy, giving his first name and age, which shall not be less than twenty-one years, and residence; second, the name of the school or college of osteopathy from which he graduated, which shall have been in good repute as such, at the time of the issuing of his diploma, as determined by the board; third, the date of his diploma, evidence that such diploma was granted on personal attendance and completion of the course of study of not less than four terms of five months each, and such other information as the board may require, and sufficient evidence that the applicant is of good moral character. Such application shall be accompanied by a fee of twenty-five dollars. No holder of a diploma issued after June, 1907, shall be admitted to an examination, nor shall a certificate to practice osteopathy be otherwise granted by said board, to any such applicant unless said applicant shall have a diploma of graduation from a high school, academy, state normal school, college or university, a certificate of examination for admission to the freshman class of a reputable literary or scientific college, approved by aforesaid board, as a preliminary education before taking up the study of osteopathy, and shall have graduated, after personal attendance, from an osteopathic school or college of good repute wherein the course of study shall consist of at least three years of nine months each, in three separate years, and after June, 1915, said applicant shall have a diploma of graduation from a high school, academy, state normal school, college or university, a certificate of examination for admission to the freshman class of a reputable literary or scientific college, approved by the aforesaid board, before taking up the study of osteopathy, and shall have graduated, after personal attendance from an osteopathic school or college of good repute wherein the course of study shall consist of at least four years of eight months each in each separate year; provided however, that if any applicant shall have completed a course of study in any such osteopathic school or college, consisting of three years of nine months each, and a post-graduate course of at least five months, aggregating at least thirty-two months, such course shall be accepted in lieu of the full period of four years of eight months each provided for in this act. The board shall subject all applicants to a practical examination, as to their qualifications for the practice of osteopathy, in writing, in the subjects of anatomy, physiology, physiological chemistry and toxicology, pathology, diagnosis, hygiene, obstetrics and gynecology, surgery, principles and practice of osteopathy, and such other subjects as the board may require. This may be supplemented by other practical examinations such as the board may by rule determine. If such examination is passed in a manner satisfactory to the board, then the board shall issue to said applicant a certificate granting him the right to practice osteopathy in the state of Kansas, as taught and practiced in the legally incorporated colleges of osteopathy of good repute. All examination papers shall be recorded and kept by the board. Any person failing to pass such examination may be re-examined at any regular meeting of the board within one year from the time of such failure, without additional fee; provided, that a physician's certificate issued by a reputable school of osteopathy to a graduate from a reputable school of medicine after an attendance in an osteopathic school or college of good repute, of not less than two terms of five months each, may be accepted by the board the same as a diploma, and the holder thereof be subject to the same regulations in all other respects as other applicants before the board; provided, that after the year 1908, he shall have attended two terms of not less than nine months each

in two separate years; provided, that after the year 1915 he shall have attended three terms of not less than eight months each in three separate years; provided further, that the board may, in its discretion, dispense with an examination in the case, first, of an osteopathic physician duly authorized to practice osteopathy in any state or territory or the District of Columbia or any foreign country, who presents a certificate of license issued after an examination by a legally constituted board of said state, territory, District of Columbia, or foreign country, accorded only to applicants of equal grades with those required in this state; or second, an osteopathic physician who has been in actual practice of osteopathy for five years prior to the application for license, and who is a graduate of a reputable school or college of osteopathy, who may desire to change his residence in this state and who makes application on a form to be prescribed by the board, and accompanied by a fee of not less than that of the state, territory, District of Columbia or foreign country, from which they come, which shall not be less than fifty dollars. The secretary of the board may grant a temporary permit until a regular meeting of the board or to such time as the board can conveniently meet, to one whom he considers eligible to practice in the state and who may desire to commence the practice immediately. Such permit shall only be valid until legal action of the board can be taken. The board may refuse to grant a certificate to any person convicted of felony or of gross unprofessional conduct, or who is addicted to any vice to such degree as to render him unfit to practice osteopathy, and may, after due notice and hearing, revoke such certificate for like cause.

Sec. 3. The words, "osteopathic school or college of good repute," wherever used in this act, shall be deemed and taken to include only such schools or colleges of osteopathy as are legally incorporated, and which prescribe a course of study covering the time provided for under the provisions of this act, and which shall instruct in all the branches of study in which examinations are required for license under the provisions of this act, and shall require the personal attendance of the student throughout the course, and the requirements of which shall be in no particular less than those prescribed by the American Osteopathic Association.

Sec. 4. All fees shall be paid in advance to the treasurer of the board, to be by him held as a fund for the use of said board of osteopathic examination and registration. The compensation and expenses of the officers and members of said board, and all expenses necessary and proper, in the opinion of said board, to discharge its duties under and to enforce the law, shall be paid out of said fund, upon warrants of the president and secretary of said board, and no expenses shall be incurred to exceed the income of fees or fines, as herein provided, nor shall any compensation be paid in excess thereof, and said compensation and expenses shall not exceed ten dollars per day. Any surplus above two hundred dollars which may remain after the payment of expenses and compensation as aforesaid shall be paid annually to the state treasurer for use of the state. It shall be the duty of said board to make a report of its proceedings to the governor annually, on or before the first day of March, which report shall include an account of all moneys received and disbursed by said board.

Sec. 5. Osteopathic physicians shall observe and be subject to all state and municipal regulations relating to the control of contagious diseases, reporting and certifying births and deaths, and all matters pertaining to public health, the same as all schools of medicine, and such report shall be accepted by the officers of the district to whom the same are made.

Sec. 6. Every persons holding a certificate from the state Board of Osteopathic Examination and Registration shall have it recorded in the office of the county clerk in the county in which he expects to practice. Until such certificate is filed for record, the holder shall exercise none of the rights or privileges therein conferred. Such recorder shall keep in a book for that purpose a complete list of all certificates recorded by him, with the date of the recording of each certificate. Each holder of a certificate shall pay to said clerk a fee of one dollar for making such record.

Sec. 7. Any person who shall practice or pretend or attempt to practice, treat or attempt to treat, for pay, or in any way use the science or system of osteopathy in treating diseases of the human body, by fraud or mis-

representation, or any person who shall buy, sell, or fraudulently obtain any diploma, license record or registration to practice osteopathy, illegally obtained or signed, or issued unlawfully, or under fraudulent representation, or shall use any of the forms or letters, "osteopathy," or "osteopathist," "diplomat in osteopathy," "D. O.," "osteopathic physician," "doctor of osteopathy," or any other title or letters, either alone or with other qualifying words or phrases, under such circumstances as to induce the belief that the person using such term or terms is engaged in the practice of osteopathy, without having complied with the provisions of this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined not less than fifty nor more than two hundred dollars for each offense, or be imprisoned not more than six months in the county jail, or by both fine and imprisonment. Nothing in this act shall be construed to prohibit graduate osteopaths residing outside of the state of Kansas, meeting in consultation with osteopaths of this state.

Sec. 8. That section 8087 of the General Statutes of the state of Kansas of 1909, be and the same is hereby amended to read as follows: Sec. 8087. All persons intending to practice medicine or surgery after the passage of this act, and all persons who shall not have complied with section 2 of this act, shall apply to said board at any regular meeting, or at any other time or place as may be designated by the board for a license. Application shall be made in writing, and shall be accompanied by the fee hereinafter specified, together with the age and residence of the applicant, proof that he is of good moral character, and satisfactory evidence that he has devoted not less than three periods of six months each, no two within the same twelve months, or if after April 1st, 1902, four periods of not less than six months each, no two in the same twelve months, to the study of medicine and surgery. All such candidates, except as hereinafter provided, shall submit to an examination of a character to test their qualifications as practitioners of medicine or surgery, and which shall embrace all those topics and subjects a knowledge of which is generally required by reputable medical colleges of the United States for the degree of doctor of medicine: Provided, that the examination in materia medica and therapeutics and in the theory and practice of medicine shall be conducted by those members only of the board who are of the same school of practice as the applicant claims to follow: Provided further, that graduates of legally chartered medical institutions of the United States or foreign countries in good standing, as determined by the board, may be, at the discretion of the board, granted a license without examination: Provided further, that the board may in its discretion accept, in lieu of examination or diploma, the certificate of the board of registration and examination of any other state or territory of the United States or any foreign country whose standards or qualification for practice are equivalent to those of this state: Provided, that a temporary certificate may be issued to any student of medicine or practitioner of medicine who is not qualified under the law, upon the written request of a majority of the practitioners of medicine under this act in the county in which he desires to practice, or, if there be no practitioners registered under this act in any county in this state, the board shall issue a temporary permit as above described upon the application of the board of county commissioners of said county.

Sec. 9. That section 8088 of the General Statutes of the state of Kansas of 1909, be and the same is hereby amended to read as follows: Sec. 8088. Upon the completion of the examination or the acceptance of the diploma or certificate as herein provided, the said board shall, if it finds the applicant qualified, grant and issue a certificate to said applicant to practice medicine and surgery within this state, and which will be signed by the president and secretary and attested by the seal of the board. Within thirty days of the date of any certificate of license having been granted and issued by the board, the owner thereof shall have it recorded as hereinafter provided in the office of the clerk of the county in which he resides, or, if a non-resident of the state, then of the county in which he has an office or intends to practice, and the date of recording shall be indorsed thereon; and until such certificate of license is recorded he shall not exercise any of the rights or privileges therein conferred. The county clerk shall keep in

a book for that purpose a complete list of the certificates recorded by him, which book shall be open to public inspection during business hours. Between the 1st and 20th days of December of each year, the county clerk shall furnish the secretary of the board a list of all certificates recorded and in force, and also a list of all certificates which have been revoked or the owners of which have removed from the county or died during the year. The fee for the recording and reporting of such certificates shall not exceed one dollar.

Sec. 10. That section 8090 of the General Statutes of the state of Kansas, of 1909, be and the same is hereby amended to read as follows: Sec. 8090. Any person shall be regarded as practicing medicine and surgery within the meaning of this act who shall prescribe, or who shall recommend for a fee, for like use, any drug or medicine, or perform any surgical operation of whatsoever nature for the cure or relief of any wounds, fracture or bodily injury, infirmity or disease of another person, or who shall use the words or letters "Dr.," "Doctor," "M. D.," or any other title, in connection with his name, which in any way represents him as engaged in the practice of medicine or surgery, or any person attempting to treat the sick or other afflicted with bodily or mental infirmities, or any person representing or advertising himself by any means or through any medium whatsoever or in any manner whatsoever, so as to indicate that he is authorized to or does practice medicine or surgery in this state, or that he is authorized to or does treat the sick or others afflicted with bodily infirmities, but nothing in this act shall be construed as interfering with any religious beliefs in the treatment of diseases: provided, that quarantine regulations relating to contagious diseases are not infringed upon. This act shall not apply to any registered osteopathic physician or any chiropractic practitioners of the state of Kansas, or any commissioned medical officer of the United States army, navy or marine service in the discharge of his official duties; nor to any legally qualified dentist, when engaged in the legitimate practice of his profession; nor to any physician or surgeon who is called from another state or territory in consultation with a licensed physician of this state, or to treat a particular case in conjunction with a licensed practitioner of this state, and who does not otherwise practice in the state. Nor shall anything in this act apply to the administration of domestic medicines, nor to prohibit gratuitous services: provided, any person holding a diploma issued by an optical college, and who has studied anatomy of the eye and contiguous parts, human physiology and natural philosophy for at least six months under a competent teacher, and who shall pass examination satisfactorily to the state board of medical registration and examination, shall be eligible to register as an optician or doctor of optics, and shall be otherwise governed by this act so far as the same is applicable.

Sec. 11. That section 8091 of the General Statutes of the state of Kansas of 1909, be and the same is hereby amended to read as follows: Sec. 8091. From and after the 1st day of September, 1901, any person who shall practice medicine and surgery in the state of Kansas without having received and had recorded a certificate under the provisions of this act, or any person violating any of the provisions of this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall pay a fine of not less than fifty dollars nor more than two hundred dollars for each offense' and in no case where in this act shall have been violated shall any person so violating receive compensation for services rendered. It shall be the duty of the secretary of the State of Board Registration and Examination to see that this act is enforced.

Sec. 12. That section 8093 of the General Statutes of the state of Kansas of 1909, be and the same is hereby amended to read as follows: Sec. 8093. That the secretary of the state board of medical registration and examination may in his discretion issue a temporary permit to practice medicine, or surgery to any person who shall have made application in writing to said board for license to practice, accompanied by the prescribed fee, and proof as required by section 3 of chapter 254 of the Session Laws of 1901, and who shall be a graduate of any legally chartered medical institution of the United States or any foreign country; or such permit may be so issued to any such applicant for license, complying with said conditions, who is shown to have been licensed by the board of registration and exami-

nation in any other state or territory of the United States or any foreign country whose standards of qualification for practice are equivalent to those of this state. Any such temporary permit so issued shall, when recorded in the office of the county clerk in the county in which he resides, authorize the person receiving the same to practice medicine or surgery in the same manner as a permanent license up to the commencement of the next regular meeting of the state board of medical registration and examination following the date of issue when such permit shall expire: Provided, that neither the said board nor the secretary thereof shall have power to issue more than one temporary permit to any one person, nor to extend any such permit beyond the time herein limited.

Sec. 13. That section one of chapter 297 of the Session Laws of the state of Kansas of 1911, be and the same is hereby amended to read as follows: Sec. 8089. "Section 5. The fee for the issuance of a certificate to all those found qualified to practice medicine or surgery without examination, as provided under section 2, shall be two dollars. The fee for examination shall be fixed by the board, but shall not exceed fifteen dollars. The fee for examination of diploma or certificate from an examining board of another state shall also be fixed by the board, but shall not exceed ten dollars. All moneys received by the board shall be paid by the secretary thereof into the state treasury monthly. The compensation and actual traveling and other expenses of the board shall be paid from the treasury of the state; provided, that the total amount paid from the state treasury under the provisions of this act shall not exceed the amount paid into the treasury as herein provided. The compensation of the members of the board shall be six dollars for every day actually spent in the discharge of their duties. In addition to his actual traveling expenses the secretary shall receive a salary, to be fixed by the board, but it shall not exceed eight hundred dollars per annum. The secretary shall also appoint a stenographer who shall receive a monthly salary to be fixed by the board, but such salary shall not exceed sixty dollars a month. All such compensation and traveling expenses shall be approved by the president and secretary of the board. It shall be the duty of said board to make a report of their proceedings to the governor annually, on or before the 15th day of November, which report shall include an account of all moneys received, and disbursed by them."

Sec. 14. That said original sections 8087, 8088, 8090, 8091 and 8093 of the General Statutes of the state of Kansas of 1909, and section one of chapter 297 of the Session Laws of 1911 be and the same are hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the statute book.

—O—

SOCIETY NOTES.

1st District, C. W. Reynolds, Councillor, Holton:

The first meeting in 1913, of the Brown County Medical Society was held in Hiawatha, April 8, being postponed from January on account of bad roads. The following officers were elected: President, H. J. Deaver; Vice-President, W. G. Attwood, both of Fairview; Secretary-treasurer, H. J. Harter of Horton. Censor, J. O. Ward, Horton; delegate to state society, L. W. Shannon of Hiawatha. A resolution was passed condemning advertising by cards in telephone directories, programs and similar publications and that local newspapers be requested not to mention any physicians' name in connection with a case. The following program was given:

"Tuberculosis of the Hip Joint, With the presentation of a case." L. W. Shannon, Hiawatha.

"Serum and Vaccine Therapy". Dr. W. C. Palmer, Hiawatha.

"Diagnosis of Gall-Stone". Dr. L. Reynolds, Horton.

The next meeting will be July 8, at Horton.

H. J. HARTER, Secretary.

—o—

4th District, W. E. McVey, Councillor, Topeka:

At the annual meeting of the Golden Belt Medical Society, held at Junction City, April 3rd, Dr. R. C. Lowman of Kansas City was elected president and Dr. W. A. Carr of Junction City, secretary.

—o—

5th District, W. E. Currie, Councillor, Sterling:

Program of the Harvey County Medical Society for May:

"SURGICAL GYNECOLOGY."

"Repair of Old Complete Perineal Lacerations." Dr. R. H. Hertzler.

"Significance of Uterine Hemorrhage." Dr. H. A. Seehorn.

"Vaginal Hysterectomy." Dr. J. T. Axtell.

Review of Recent Literature or Report of Case. Dr. R. S. Haury.

F. L. ABBEY, Sec'y.

—o—

7th District, W. F. Sawhill, Councillor, Concordia:

Our county society met at Osborne, April 7th. Dr. P. D. Brown of Alton read a paper on needed medical education and regulation. Dr. H. R. St. John lectured on local anesthesia as now perfected in Europe.

The committee of five appointed by the society to investigate the tuberculosis sanatorium at Natoma, Kansas, reported as follows; To Osborne County Medical Society,

We, your committee, appointed to investigate the Sunny Sanatorium located a little South of Natoma, Kansas, find that its financial cost was about \$12,000. It is clean, well-kept, well lighted and well ventilated. They had one patient at time of our visit. It has been conducted on non-ethical principles. We cannot indorse it or recommend the purchase of its stock as an investment.

PORTER D. BROWN,

H. W. NYE.

E. O. HENSHALL,

B. F. CHILCOTT.

C. L. EBNOTHER.

Committee.

The above committee was appointed at the request of the local manager, Jake Isenberger of Natoma, who agreed to pay expenses of committee in order that he might get the approval of State Bank Commissioner for sale of stock. The methods were too searching to meet the approval of the manager, so our committee paid its own expenses.

W. W. MILLER, Secy.

NEWS NOTES

The annual meeting of the Medical Association of the Southwest will be held in Kansas City, Mo., October 7-8.

Dr. Virgil W. McCarty of Rosedale, was married April 12, to Miss Bernice French of Lawrence.

Dr. Jesse Thomas Orr, Olathe, has been appointed a member of the Board of Medical Examination and Registration.

Dr. J. E. Foltz, physician at the state reformatory, Hutchinson, has resigned.

Dr. F. Campbell, city physician of Kansas City, Kansas, has returned from an extended trip in Montana.

At the spring election in Kansas City, Kansas, Dr. J. A. Fulton and Dr. Jessie Newkirk were elected members of the Board of Education. Dr. Fulton was elected to succeed himself.

At the annual Methodist Episcopal Conference of Southwest Kansas, held in Wichita, recently, it was decided to purchase a five-acre tract of land in Wichita, on which the Wesleyan Hospital is to be rected at a cost of \$200,000.

Dr. G. M. Cassell of Long Island was operated upon for recurrent appendicitis by Dr. Lathrop at the Norton Cottage Hospital on April 16.

The entirely new and up-to-date ear, nose and throat equipment of the late Dr. S. C. Emley, will be on sale Saturday, May 17th, at 2 p. m., at 2120 N. 5th St., Kansas City, Kansas.

OBITUARY.

Clarence Brock Goddard, A. B., M. D., Leavenworth, Kansas, died at home of his parents, March 30th, 1913. Born August 25th, 1878. Graduate of K. U. as Bachelor of Arts, 1904; degree of medicine 1909, Denver-Gross Medical College, Denver, Colorado. A lovable gentleman, a brilliant young physician, beloved by all who knew him, stricken down at the threshold of his career. *Requiescat* in peace.

James F. Flynn, M. D., Chicago Homeopathic Medical College, 1893; died at his home in Humboldt, Kan., February 1, from cerebral hemorrhage, aged 50.

William P. Booker, M. D., Kansas City (Mo.) Hospital College of Medicine; 1885; died suddenly at his home in Caney, Kan., recently.

Joseph De Weese Stevens, M. D., Jefferson Medical College, 1883; a member of the Kansas Medical Society; died at his home in Peru, March 9, from cerebral hemorrhage, aged 79.

Francis Marion Loper, M. D., Indiana Eclectic Medical College, Indianapolis, 1885; died at his home in Atchison, Kan., March 10, aged 69.

RESOLUTIONS.

Resolved, That this, the Southwest Kansas Medical Society, wishes to direct the attention of the medical profession, to the secret division of fees, as practiced in Kansas, which is destroying public confidence in the profession and interfering with development of competent surgeons, and calls on the state society to find some adjustment, fair to the general practitioner and surgeon, by which the element of secrecy may be eliminated.

Resolved, That a copy of these resolutions be published in the Journal of the Kansas Medical Society, and farther, be it

Resolved, That these resolutions be presented through the proper channels to the Kansas Medical Society, at Topeka, May 7th and 8th, 1913.

GEO. S. SMITH, M. D.

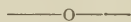
REVIEWS.

Nephrectomy Without Drainage for Tuberculous Kidney—By William J. Mayo (Surg., Gyn. and Obstet., November 1912.)

Following nephrectomy for tuberculosis of the kidney it was formerly the practice of the writer to drain, especially if tuberculous material escaped into the wound. A slowly healing sinus often formed and in many instances mixed infection with supuration occurred, undoubtedly a contributing factor in failure to cure the patient. About two years ago while operating upon a tuberculous kidney, a large quantity of whey-like fluid was found outside the kidney. After removing the kidney and treating the ureter, the wound and cavity (holding more than a quart) were filled with normal salt solution and wound closed without drainage. Primary union and permanent recovery followed. Since then, in operating on these cases, if tuberculous material soils the wound, it is cleansed as well as possible, filled with normal salt solution and closed without drainage. The writer believes the normal salt solution enables the material which is infected with tuberculosis in the attenuated state to be safely absorbed because diluted and absorbed quickly before there is opportunity to establish favorable cultural conditions which would increase the virulence of the organisms. Where tuberculous material does not escape into the wound the salt solution need not be used, and drainage should not be employed. The tuberculous material should not be allowed to escape if possible to prevent it and this regains adequate incision.

The patient is placed on the sound side with a considerable degree of elevation of the loin. A vertical cut frees the twelfth rib from its posterior attachments and a long transverse incision mobilizes the lower wall of the thorax. In this manner a large kidney can be removed with ease.

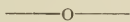
Regarding the treatment of the stump of the ureter the writer says "for a number of years it has been our practice to inject 10 to 20 minims of carbolic acid (liquid 95 per cent.) into the ureter." A ureter thus treated will rarely give trouble later.



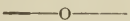
Vaccines in Suppurative Otitis Media—Christie in the New York Medical Record of September 28, 1912, says that from his own experience and the experience of others he thinks it can now be stated that the use of vaccine treatment in acute suppurative

otitis media should be confined to those cases which are resistant to local treatment, and then it should be used in addition to, and not to the exclusion of, such treatment. It is undoubtedly a valuable addition to our present means of treating such cases. In addition to these acute cases it is the general opinion of men who have used them that vaccines are of value in most subacute cases. In chronic cases their field of usefulness is much more restricted, depending probably upon two factors, the amount of necrosis and the condition of the circulation in the mastoid. Enough cases have been reported by different observers to show that vaccines are an aid to the treatment of chronic cases even of long standing, but of course the more the disease becomes the more is it likely that operative measures will be necessary to effect a cure.

Even with the above limitations it must be acknowledged that vaccines have a definite place in the treatment of suppurative conditions of the middle ear. The dangers accompanying a chronic otitis media are being recognized now as never before, and if the vaccines will prevent a certain number of cases from becoming chronic, and limit the ravages of the disease in those already chronic, then their use is not only justified but becomes highly imperative.—Therapeutic Gazette.



Intermittent Pyuria—A. J. Underhill, Baltimore (Journal A. M. A., April 5), reports two cases of intermittent pyuria diagnosed as due to infection of the prostatic utricle. In each case the posterior examination of the urethra through the endoscope showed the verumontanum swollen and edematous and pus could be washed out from the utricle. The condition was relieved by injections of 1 per cent silver nitrate and in the second case the same, later replaced by quickly withdrawn injections of 1:1000 solution of liquor formaldehydi. The point of interest in the cases was the intermittent pyuria lasting a day or so and followed by a disappearance of all symptoms during the intervals until sufficient pus accumulated for the pressure to overcome the resistance offered by the adherent opening to the utricle. Another point of interest in the second case is the fact that the ejaculatory ducts opened into the utricle, as spermatozoa appeared every time it was aspirated. It is surprising that the seminal vesicles and the epididymis were not also infected more severely than was the case.



Variola and Vaccinia—P. M. Ashburn, Washington, D. C., (Journal A. M. A., April 19), offers the following explanation of

the relationship of variola and vaccinia. The basic facts, that small-pox contagion or inoculation produces a highly contagious and largely fatal disease, but that after being passed through cattle and monkeys for a few generations and then passed back to man it causes vaccinia, a localized, non-contagious disease with no mortality of itself and never regains the former virulence, are explained by him as follows: "1. The germ of small-pox by passage through certain lower animals loses (acquires) certain properties, and it transmits its altered condition to its offspring forever, a more striking instance of hereditary transmission of acquired characteristics than has ever before (so far as I know) been cited. 2. Small-pox is due to a dual and divisible virus, one part of which causes vaccinia and the specific small-pox eruption, the other part being necessary for the production of the contagious, generalized, mortal disease with a distinct preeruptive stage and initial rashes. The latter is the favored explanation, both because it seems more reasonable and because it is supported by numerous well-established facts." As evidence favoring this explanation he cites examples of other viruses which seem to show a similar duality and animal poxes and variolation of animals. Also the clinical observations as follows: "A. The three forms of small-pox not showing a pock stage, or only an incomplete one, purpura variolosa, varioloid and variola sine exanthemate, occur in vaccinated persons as often as, or more often than, in unvaccinated. B. Vaccinia therefore protects against the pox stage of small-pox rather than, or to a greater degree than, against the whole disease. C. Twenty-two per cent of 2,601 persons who had had variola or been variolated were still susceptible to vaccinia, though immune to small-pox. His views will be given in fuller detail in the Phillippine Journal of Science and in the Military Surgeon. In the meantime he hopes that those who have the opportunity with small-pox cases will test them further by experimental work.

—o—
FOR SALE.

Doctor:—I have practiced medicine for 25 years and have acquired a competency. I am offered a salaried position where I can take it easier. I have a practice in a good, live county seat, yielding \$3500.00 cash for 10 years, which I will surrender to some good man and stay in partnership to introduce. Have a small stock of medicines and modern home at cost. No antiquated office equipment to buy. No bonus for practice.—Address S. M., Care Journal.



DR. M. F. JARRETT,
PRESIDENT KANSAS MEDICAL SOCIETY,
1913-14.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, JUNE, 1913.

No. 6

SOME CASES OF BRAIN SURGERY IN A COUNTRY DOCTOR'S PRACTICE.

DR. E. E. LIGGETT, Oswego, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

Any physician that has had much experience in country practice, must have noticed the infrequency of brain injury cases in his work. The few cases that do occur, are generally so quickly fatal, that opportunity for surgical intervention is not often given; and, we regret to say, that sometimes, the indications for immediate, active, surgical interference are not recognized, or are misinterpreted, and a curable patient is allowed to die.

This paper is an attempt to tell in a simple manner, what was found unusual in a few of the cases of brain surgery that occurred in the practice of a country doctor; and to recite the lessons learned therefrom. It may be taken also, as a protest against the do-nothing or waiting-policy occasionally adopted in similar cases.

Descriptions of surgical technique, or of surgical methods, together with pathological findings will be omitted; or at least limited to making clear the conditions found, and to showing how these conditions were revealed and treated.

The so-called unusual elements may be, and no doubt are, quite common in certain clinics for brain injuries; but, because of the rarity of such cases in the practice of a country doctor, these matters attracted my attention, and were observed with interest.

In the recital of these cases I call your special attention to:

First: The wonderful tolerance of the human brain to severe, traumatic, disorganizing lesions.

Second: The urgent need for prompt and proper surgical intervention in all crushing injuries of the skull and brain, not immediately fatal.

Third: The great danger of traumatic epilepsy developing after a brain injury; especially in those cases not properly treated soon after the receipt of the injury.

Fourth: The certain, prompt and fairly safe cure for trifacial neuralgia, by the removal of the Gasserian ganglion.

Case 1. Lee M. a male, aged 26, a freight brakeman. Family history shows: Mother nervous, one sister hysterical, and another subject to severe headaches, otherwise negative. Personal history shows only the usual diseases of childhood, and a severe attack of inflammatory rheumatism when sixteen years old. No nervous affections of any sort.

About sixteen months before my examination, while doing his work on top of a freight car, he was struck on the head by a low bridge and knocked down. Unconscious, he rolled off the top of the rapidly moving car, and fell in a stony ditch by the side of the track. He was picked up by the train crew, terribly bruised and with his skull crushed in over the left ear, with blood and brains oozing from the wound.

He was taken to the railroad hospital at once, and put in the "dying ward", where he remained for two days. Then he was transferred to the regular surgical ward. After ten days or two weeks, he became violent and obstreperous, although he was unable to talk, and was not conscious of his acts. A little later he was taken before the Probate Court, declared "insane", and a guardian was appointed for him. He was then (about six weeks after the injury) returned to the hospital and operated upon for "depressed fracture of the skull." The next morning he could talk; was conscious of his condition, and of where he was. He made a rapid recovery mentally, and was never sent to an insane asylum. He also made a quick recovery from the operation for the depressed fracture; but, he was never strong and made only a few trips on the road again as a brakeman.

About fifteen months after the time of the injury, he had a moderately severe fit. In a short time this was repeated. After the second fit he came under my care complaining of pain in the wound area, and he was "sure there was a bone pressing down on his brain." He was referred to Doctor Perry, Superintendent of the State Hospital for Epileptics, who confirmed the diagnosis of "traumatic epilepsy," and advised that the wound be reopened, the scar tissue separated from the dura and a plate put in. He further advised the raising of any bone found depressed, and if necessary, the opening of the dura, and the examination of the tissues beneath.

This operation was done. The adhesions between the scar tissue and the dura was found quite dense and strong, but were separated without much trouble by means of blunt dissection, with the occasional snipping of particularly strong bands of ad-

hesions. The major portion of the broken fragments had been removed at the former operation leaving an opening in the skull about the shape and size of the bowl of a large tablespoon. At the anterior end of this opening there was found a piece of the inner table, about one and one-fourth inches long by one-half inch wide, which had been left in place, but depressed, at its inner margin, fully three-eighths of an inch. This piece was removed and the internal edge of the entire opening was rounded off. The dura bulged, and was opened by a crucial incision.

There were no adhesions beneath the dura, except under the right upper quadrant of the opening. Here they seemed dense, but, while lifting up the point of this quadrant, with some force, and using the blunt dissector on one little band more prominent than the rest, this band gave away and the whole thing peeled off the pia, easily and quickly. It seemed like lifting a lid off the opening of a little sack or cyst; that was below and that pointed straight into the brain tissue. This sack or cyst, seemed about the shape and size, including the length, of a small pecan nut; and it was filled with a clear liquid.

Immediately after the dura was stripped loose, and quicker than it can be told, this cyst emptied itself of its contents in a manner that gave me the impression that the top of the cyst was being stretched, or was opening, while its walls were shortening, and its bottom was coming to the surface, as indeed it was. In less than twenty seconds there was no trace of a sac or cyst, except the widely spread, slightly marked ring where the adhesions had been.

The phenomenon of this cyst is the unusual feature of this case. The following explanation of its existence is ventured. There must have been an area of pachymeningitis, severe enough at the edges to cause adhesions all the way around; while in the center of this area there was an absence of inflammation, or its degree of severity was insufficient to cause adhesion, or to destroy the secretory power of the arachnoid. This secretion, and the gradual collection of the fluid formed the cavity of the cyst by the steadily increasing accumulation pushing its way in the direction of the least resistance, or into the tissues of the brain. No doubt this increase in the inter-cranial pressure was an important factor in causing the pain lately complained of, in the wound area.

An aluminum plate was put in. The wound healed nicely; the patient regained a large measure of his old time strength; but, in about ten months, he again began to have epileptic fits with increasing frequency; finally he began to dement, developed acute pulmonary tuberculosis and died. No autopsy.

The lessons of this case are first: the folly of the "do-nothing," or waiting policy. It is probable that an early operation would have prevented the meningeal inflammation that resulted in the cyst and the consequent brain pressure. Second: the futility of an incomplete operation. Had all the depressed bone been raised; the inner edge of the opening rounded off, and a plate put in, it is possible that the epilepsy might have been avoided, and the patient might have remained a well and hearty man.

Case 2. Chas. K., aged twenty years, an insane epileptic of good family history. When ten years old, while playing "Black-man" at school, was thrown backward, striking his head violently on the frozen ground. He was unconscious for several hours and was not able to return to school for two weeks. Before the injury he had been an obedient, bright boy and a good student. On return to school he was dull, apathetic and slow in his studies. He complained of headache and was inattentive. About three months after the fall he had a fit in school. In a week or two this was repeated and the fits gradually increased in frequency and severity. His mental dullness so increased that the next fall, he was taken out of school and never returned. He gradually developed so violent a temper that he was uncontrollable; and when he was eighteen years old, there being no epileptic colony in the state at that time, he was declared "insane" and sent to one of our state asylums, which was under a different management than at present. After he had been there a year or more his people became dissatisfied and brought him home. His vicious temper and habits, and his irresponsibility, made him a terror to his family and friends. His father believed that his skull had been crushed in at the time of the fall; and as he had heard that some similar case had been much benefited by raising the depressed bone, he brought the boy to me, asking to have this done for him.

After shaving the scalp, we found what seemed to be quite a distinct depression about an inch to the left and an inch anterior to the occipital protuberance. A button of bone one and one-fourth inches in diameter, which included all the depressed area, was taken out. The dura beneath seemed normal and was not opened.

Running up over the skull, parallel to the sagittal suture and about an inch to the left, was an apparently depressed line, as though, at the time of the accident, there might have been a fissure of the parietal bone. It also seemed on examining the trephine opening, that under this line the bone was slightly thickened. We could not be sure, however, that this was not a natural

irregularity on the inner side of the skull, and nothing further was done at that time. The boy went home in a short time apparently improved.

His father brought him back, in about six months, asking to have that line cut out. He said there had been some improvement, but the temper and habits were still unbearable. The depressed line was taken out, leaving an opening in the skull four and one-fourth inches long by one inch wide. The recovery was rapid and uneventful.

After two years his father reported that the boy was quite docile and obeyed readily; his temper was about like that of any other spoiled child; his fits were less severe and a little less frequent; his habits were as vile as before; but, altogether there was a marked improvement, so the family could now endure the boy's presence in the home.

The unusual feature of this case is the long opening in the skull. The lessons learned are the need for immediate action in raising a depressed fracture, and the benefit sometimes derived, even from a later operation.

Case 3. Irvin W., aged 24, a carpenter. Family and personal history negative. Ten days before my examination, a piece of studding lumber, two by four inches, about two inches long, after falling twenty or more feet, struck endways on the right side of his head. He was knocked down and was unconscious for several hours. He was taken home and his family physician dressed the wound. This healed nicely and was soon well; but, the patient did not feel well. A numbness and twitching developed in the left thumb, then spread to the front finger, then the numbness spread, in a less degree, over the entire hand and lower arm.

On the seventh day after the accident his family physician took him to Doctor Perry. The young man came to me reporting that Doctor Perry advised a surgical operation for the elevation of a depressed fracture, believing that without it traumatic epilepsy would soon develop.

Operation on the tenth day revealed a depressed fracture of the bone just above the right temporal ridge where it was crossed by the bi-auricular line. The broken piece of bone was approximately in the shape of an irregular scalene triangle, the long side measuring one and one-fourth inches, and lying parallel to the bi-auricular line. The next longest side, superior-posterior, measured about one inch. The dura was torn and the fragment of bone was depressed, at its upper angle, about one-half an inch. The broken piece was entirely loose and came out readily. On exami-

nation a strip of the inner table, from the anterior edge of the fragment was found to be absent. On re-examining the wound this strip or splinter of bone was discovered driven straight down into the brain tissue, and was so buried that it could have been overlooked easily. It was about one-fourth of an inch wide at the base, and was one and one-fourth inches long, tapering to a sharp point at the buried end.

This splinter of bone and its position in the brain, were the unusual features of this case.

The patient made an uneventful, although rather slow recovery from the operation. There were no further symptoms of the threatened epileptic attacks, but the sensation and the power in the thumb and front finger of the left hand, have never been fully regained.

We again learn the error of dressing a scalp wound without positively excluding the possibility of a fracture that could accompany it. The fragments of bone in this case, could have been removed very easily through the original wound, and a good deal of the subsequent disturbance avoided. The promptness with which the consultant made the diagnosis and the emphasis with which he urged an early operation, probably saved this young man from traumatic epilepsy; which once established is, in most cases, permanent, and which brings with it all the deterioration generally accompanying the usual form of epilepsy.

Case 4. Riley H., a boy ten years old was kicked on the left side of the head by a rough shod mule. He was found lying in the stable behind the mule, with his wound filled with blood, brain tissue, matted hair, horse manure and other stable filth. He was at once brought to town to the hospital.

We found him unconscious with stertorous breathing, very slow pulse, much shocked and bloodless. The wound was cleansed and enlarged, and the broken and depressed bone was removed. It left an opening two and one-fourth by three inches, the long diameter being in the antero-posterior line of the skull. The toe of the rough shoe had split the bone longitudinally, and had driven it inward, much as a double gate swings on its hinges. The upper fragment, one and one-half inches wide by three inches long, driven by the toe of the shoe, had turned through nearly half a circle, directly into the brain substance of course, tearing the brain before it. At least an ounce of disorganized brain tissue was removed, and a rent into the left ventricle was plainly seen.

The opening into the ventricle and the large destruction of brain tissue were the unusual features of this case.

The wound was drained with catgut; the rents in the dura

sewed up; a plate put in and the wound dressed. The boy soon regained consciousness, but could not speak. There was a slight fever, which subsided after three days. There was a continuous, profuse, watery discharge from the drain. On the fifth day he could sit up in bed, and could speak a word or two, but could not use the right word (paraphasia.)

On account of certain circumstances in his home, he was allowed to leave the hospital on the eighth day, although the wound was still draining. Otherwise his condition seemed ideal. At his home, through the meddlesomeness of some of his family, the dressings were removed, and the wound became infected on the tenth day. A violent encephalitis immediately began and was followed by the breaking open of the skin wound; the opening of the dura; the discharge of the plate; and the establishment of a large cerebral fungus. The boy had a high fever, lapsed into coma and died on the fourteenth day.

The lesson this case taught was the necessity for keeping the patient under responsible care until the wound entirely healed. I firmly believe this boy would have made a nice, smooth recovery from the injury and operation had the wound not become infected through mismanagement. Whether neurosis, such as epilepsy, insanity, paralysis, etc., would have developed as a result of the traumatism to the brain, can be conjectured only.

Case 5. Frank G., a drayman, aged forty years. A heavy box of canned goods fell from the top of a high load of dray stuff and struck him on the head. He was knocked down and dazed, but soon got up and drove his loaded team home. He was much bewildered when he got there and soon became comatose. The accident happened at about nine o'clock a. m., and at nine p. m., the same day, his physician asked me to see the patient with him. We found the scalp wound nicely cleansed and dressed, but still oozing blood. The patient was dying and passed away in a few minutes. We were allowed to make a post-mortem examination of the wound only. There was a compound, depressed fracture on the right side of the skull just above the ear. The bone was badly broken, but was not greatly depressed. The dura was intact, but bulging. On incising this membrane about four ounces of fluid and clotted blood were turned out. The middle meningeal artery was torn, but in such a position that it could have been ligated easily.

The unusual, or rather unexpected feature of this case was that so small a hemorrhage under the dura, could cause death. We had expected a larger quantity of blood under the dura than was

found. The lessons learned were: the error of delay in raising the bone, opening the dura, and checking the hemorrhage. This case had the least destruction of the brain tissues of any of the series; yet it was the only one quickly fatal, and the autopsy showed an easy and almost certain remedy—neglected.

Five cases are too few to justify positive conclusions, but it is possible to make them the basis for the belief that the brain is much more tolerant of serious, disorganizing injuries than is commonly supposed; and that its recuperative qualities, so far at least, as the functions of life are concerned, are as good as those of the abdominal organs. Every doctor then, ought to be prepared to give such cases as have been described, prompt surgical attention; or, failing to be so prepared himself, he should consider it his solemn duty to call to his assistance at once, some other doctor that is so prepared.

Now, if it be true, as above shown, that the human brain is wonderfully tolerant of disorganizing lesions occurring under the ordinarily adverse circumstances surrounding accidental injury, how much more likely is it to be true that a well designed surgical operation, when the matters of time and surroundings, of general health and bodily conditions, are all more or less under our control, will find the brain not merely tolerant, but actually ready to respond to the surgical invitation to health? In other words, is it not proper to conclude that a definite surgical operation on the skull and brain is comparatively safe, when properly performed, and is justifiable, and is strongly indicated when there is need for its performance to restore health, or to cure unbearable pain? As an illustration of the strength of this position permit me to recite briefly, the history of one more case.

Case 6. Levi M., aged 65, male, retired farmer. Family history negative. Personal history shows nothing except alcoholism and morphinism, the result, he claims, of the ailment for which he seeks relief.

He had "suffered the tortures of the damned" for eleven years, with a nearly constant tic douloureux. The slightest movement of the jaws, or even a breath of air blowing on the face, was likely to bring on the most frightful, stabbing pains which continued for hours. Had taken treatment for his neuralgia, from many physicians, both regular and irregular. Had tried all kinds of treatment, including injections of alcohol and the resection of the nerve. Had "never had one particle of relief." His suffering was so intense that his last instructions, before taking the anesthetic for operation, were to be sure to never let him awaken

if we were not able to cure him. In other words he wanted to die rather than to continue to suffer.

We did the Hartley-Krause operation for the removal of the gasserion ganglion, with complete success. There was very little shock, and at no time did we consider the patient in great danger, although the operation was tedious and difficult.

The patient sat up in bed and smoked his pipe in sixty hours; was up-town in his carriage on the twelfth day; and was out to the county fair on the eighteenth day. He had no trouble with eye on the operated side; and after several years has never had the slightest return of pain. At first there was some facial palsy, and a decided anesthesia of that side of the face and head. The palsy has largely passed away, and he quickly became accustomed to the anesthesia. He still takes whiskey because he likes it, but claims to have been cured of the morphine habit.

The unusual feature of this case is the rarity of the operation as compared to the other major operations on the human body. The lesson learned was that this or some similar operation, ought to be done in cases of tic douloureux that are now being carried along by palliative treatment; too often resulting in the undermining of the general health, the destruction of business and business habits, the alienation of friends; the unhappiness of the patients' family; his own continual suffering; and the establishment of degrading habits, such as alcoholism and morphinism, that in themselves make life a failure.

—o—

SOCIAL ACTIVITIES IN THE THIRD DISTRICT.

DR. H. B. CAFFEY, Pittsburg, Kansas.

President's Address, Southeast Kansas Medical Society, April 3, 1913.

By way of introduction I wish at this time to thank the members of the Southeast Kansas Medical Society for the honor they have conferred upon me by electing me to the chair for the past year and as my time expires with this meeting it is my desire to leave with you some thoughts upon the "Activities of Our Society in the Third District." The Southeast Kansas is one of the oldest medical societies in the Middle-West and long before the state was so organized, the physicians of this district had seen the "handwriting on the wall" and were regularly assembling for mutual exchange of ideas and the promotion of good-fellowship amongst the profession.

When organization struck Kansas, it was an easy matter for

the Third District because we were already organized and needed only to be swallowed up by the state organization and have our name changed from Southeast Kansas to Third District Medical Society. All physicians should believe in organization and strive to arouse the latent energies of each member of the profession, which, when done, would furnish sufficient force to make any reasonable medical achievement possible.

While advocating thorough organization, yet, I believe it unwise to urge the enrollment as members of two classes of physicians; (1) Those who are totally indifferent to medical progress. They will do little or nothing for the society and the society can do but little for them, yet they are the most likely to need, and the most likely to claim these benefits and protections. (2) Those known to be highly immoral, and I am sorry to admit that such there are no matter what their education, scientific attainments or activities in the community in which they live. A highly educated person may be a moral leper and capable as such, when wearing the badge of membership, of doing far greater harm than he otherwise could do. We must remember that the public holds our societies more or less responsible for the conduct of its members. We cannot reform them nor can we afford to harbor and thus bestow respectability on these professional moral monstrosities.

My work as councilor for this district during the past six years has been very pleasant and is made exceedingly simple by a united, happy and prosperous profession. There is less strife and contention, and fewer mal-practice suits, I believe than any district in the state.

I have been dissappointed year after year that more of our Southeast Kansas men did not attend the annual meeting of our state society, and that your names did not more often appear on the programs. Our state society is enjoying a flourishing growth and is extending its usefulness and influence more and more each year.

One of the newer fields taken up by the state society is the defense of its members against mal-practice suits. It is a well known fact that mal-practice suits are rapidly on the increase—New York had in 1912 an increase of more than 100%, and California reported a tremendous increase of suits filed during the last year.

1911 was the first year for our Defense Board and there were less than a half dozen suits, all were won by the state society.

There seems to be quite a difference of opinion as to the relative worth and practicability of our medical defense and from a few there has been adverse criticisms. This is unfortunate.

While, true, some of prominence and independence financially may not greatly care for financial or moral support such as is offered by the state society, yet, with the majority it is a matter of great importance, especially the moral support.

The question has been raised that the city physician profits most, while as a matter of fact, statistics show that the country practitioner in proportion to numbers, is sued more frequently than physicians in larger towns.

Suit brought against a physician practicing in a small village or in the country suffers greater injury to his practice than one located in a large town.

The cause of increase in mal-practice suits is one that should interest all and may be summed up by saying "hungry lawyers," "greedy doctors" and a "better educated public in medical questions." The public is rapidly becoming familiar with the possibilities of scientific medicine of to-day.

Medical practice is changing as medical science progresses, which should and must unite the profession in a closely co-operative as well as a strongly defensive attitude.

Practically all of our mal-practice suits have been brought in surgical cases, the great majority of them by the poor and indigent, who seem to be an easy prey to the ill-advised pleadings of a dishonest lawyer.

Though most of our suits have been brought in surgical cases, the medical defense plan should appeal to every country practitioner, as he does both medical and surgical work as it occurs in his community. Although the court holds he does not have to provide himself with an X-ray apparatus for the diagnosis and treatment of fractures or have a laboratory equipment and be qualified to make bacteriologic diagnosis, or be skilled in all the technical methods of correct diagnosis and surgical treatment; he is expected to keep in touch with his profession and to employ ordinary skill as best the circumstances and conditions will permit, which, when done, makes it very easy for the profession at large through its defense feature to offer him very strong moral support and financial aid for his defense. It is a matter of profound regret, that some physicians are so indiscreet as to make open criticism of his neighbor's work in a given case. This is found to be a frequent exciting cause for mal-practice suits. If a criticism seems warranted let it be made directly to the physician in a strictly professional and dignified way.

One of the most potent factors in the cause of mal-practice suits is the direct result of an evil that I am sorry to admit, seems

to be on the increase in this community. I refer to the problem of fee-splitting. It is too bad that the noble profession of medicine should be so prostrated by some of its members. There is little incentive to be able and to keep up, no chance for a man to be the best man; because the fellows who demand a commission would not come to you because you are the ablest, but will go to the man who pays the highest commission. And on the other hand the man who is so desirous of fame and fortune as to offer commissions for referring cases is going to be a sad disappointment to you sooner or later as his moral foundation is built upon sand. I believe the solution of this problem rests with the public and the public has taken hold of it in some neighboring communities and will take hold of it here if the conscientious and right thinking medical men who oppose all dishonest practices make it a point to seek the aid of the public in stamping out this iniquitous practice.

Governor Marshall of Indiana in a message to the present legislature said "In the interest of high professional training I recommend that the act creating the Board of Medical Registration and Examination be amended so as to require the board to revoke the license of a physician who splits his fee with an expert physician or surgeon." This is convincing evidence that the public will soon be aroused to the evils of this practice everywhere and we should welcome the day when it is effectually stamped out.

Our ideals should be of the highest and our spirit of tolerance and forbearance should be expanded to such an extent that we can better understand that our interests are mutual and that what is for the benefit of one is for the benefit of all.

We are all interested in higher medical education and to this end should lend every influence to the building up of a big institution for medical training such as is possible for the medical department of the state university. This department deserves and should have the encouragement and support of all the doctors of Kansas. There is absolutely no reason why Kansas should not rank with the foremost states in its facilities for affording a broad and comprehensive medical education. The new medical school has accomplished good work with the facilities afforded, but the time has come when the state must be liberal in its appropriations for the school, or the reputation which Kansas has through its educational institutions will fail to make good.

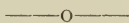
We hope that every medical man in Kansas will be sufficiently interested in this subject to use his personal influence with leg-

islators in the hope that this vital subject will be properly considered and acted on with the liberality that it deserves.

In closing, I wish to call your attention to the State Journal and ask you to read it, and when you feel so inclined write an article, an editorial or a criticism, and do your part to make our Journal more of a mouth-piece for the profession of Kansas.

We want news notes, personals and medical items of interest, especially do we want reports of county society meetings, and notices concerning the place and time of holding the meetings.

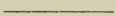
Every qualified and honorable practitioner of medicine in our state should be a member of the Kansas State Medical Society; (1) For the purpose of making a better and stronger organization, (2) from the personal good he derives from such associations, (3) it allows him at a very nominal fee, membership in his county and state society, the state Journal, and the benefits of the Medical Defense.



THE SURGICAL SITUATION IN KANSAS FROM THE GENERAL PRACTITIONERS' STANDPOINT.



DR. T. A. JONES, Liberal, Kansas.



Read before the Kansas Medical Society, May 7, 1913.

In our part of the state where there are no large towns or hospitals we are expected to call a consultant in all serious surgical cases. Surgeons know this and we have an opportunity to become familiar with some of the ways in which they get business. There are other minor methods which are interesting but are of little actual importance compared with the substantial one of dividing the fee. This method so far as we know is general and it seems that no surgeon is willing to take his chances without it. It enters as a matter of course into very consultation. After or sometimes before the operation the surgeon calls the attending physician aside and asks him what is to be done about prices. If he has decided on the amount he desires, the surgeon will add it to his bill and if necessary make his own fee small to leave room for it. If the attending physician is not specific as to the amount, the surgeon will fix the shares

himself but always makes generous provision for his consultant. If the case is sent to the hospital and the surgeon has no chance to confer with the home man in the same way the bill is made sufficiently large to cover a generous fee to him. A surgeons bill then except in very uncommon instances consists of his own fee and a commission for the man who caused him to get the case. The commission will come near averaging half of the total charge although some of the better men make a rule of one third.

If perchance, a general practitioner tells a surgeon that he wishes to make his own charge independently the latter is very much surprised and says that it is not good business. If one goes further and questions the propriety of making a charge in secret, he is told that it is the customary way. We have been told repeatedly by surgeons that there is not one of their number who does not do it and that no professional ability however great, would enable a man to succeed without it. I have never heard a general practitioner say he knew a surgeon in this state who did not split fees. Of course, there are the men who try to satisfy their consciences by telling the family that the attending physician gets a part of the fee. This is pathetic. We sympathize with these men. It shows what they would like to do if they could. The actual result however, is the same. The family must be mislead as to the amount the home physician gets or there would be no use for the surgeon to collect. It still leaves room for the poor surgeon to outbid the better one which is the pernicious feature of the method. On the other hand we have the men who appreciate the wonderful opportunity this method affords to get started in practise. They write us before we have ever heard of them offering as they express it 'to make any satisfactory arrangement as to patients.' One generous soul was willing to operate the first patient entirely free allowing us to make whatever charge to the patient that happened to suit us. I wonder how this man himself would like to be subjected to a sample operation.

The time when this improper practice crept into the transactions of the medical profession would no doubt be hard to fix but the manner of it is not specially difficult to understand. As is demonstrated to us first in the dissecting room, human beings take up the knife to use on their kind even when dead with a superstitious sort of ear. When the subject is alive, the beginner finds the operation even more awful. So years ago when surgery was still in large part unbroken ground, it required a man of great courage and strong convictions. No one was likely to undertake it unless he had had special training in one of the best schools of

this country or Europe. Giving medicine on the contrary appeared easy and without risk. So while medical men were every day associates of the laymen a surgeon was seldom seen. His operations too were occasionally attended with cures which seemed miraculous. So the surgeon was surrounded with a halo and his person partook almost of the supernatural. As usual when much impressed the people gave up their money to him readily and an operation came to stand for a large fee. For a long time the surgeon occupied this position with a great deal of honor and profit. But as schools multiplied and departments of surgery were instituted more men came out with sufficient training to make a start in that specialty. It is easy to see how these young men would be attracted to surgery as a life work. Besides being a position of more prominence it is much easier to operate for a few minutes a time or two a day than to be continually on calls day and night for general practice. Starting in practice is very slow and it would naturally occur to a man that he could afford to do surgical work below the customary price. So he begins to bid for business. It would be of little use to offer to do the work for a less price to the patient for the general practitioner who controls the selection of the surgeon has himself become accustomed to the high price. The happy thought is for the general practitioner to get a part of the bill. Having a vague idea that he is not fully appreciated and being usually necessitous, he responds very promptly and the effect on the surgeon's practice is magical. There being no mathematical basis for comparing the qualifications of different surgeons he soon convinces himself that the man who gives the biggest commission is as good as any. So this feature has become the prime consideration in the selection of a consulting surgeon.

It is worth while to examine a little and see what sort of a surgeon this system is likely to give us. Plainly the man will get most practice who is most prompt and generous in dividing the fee. Suppose a young man has had all the preliminary education that the greatest authorities advise. Suppose he has spent five years in an A 1 medical school and hospital with men of advanced thought and high ideals. Is he apt to take kindly to a system of this sort that costs him his self-respect. On the other hand, if a man's education has been neglected and he has been forced to depend upon tricks and subterfuges to conceal his ignorance he will slide gracefully into a custom for which he has had special training. Then the effect of this system must be to discourage, or drive out the better men and put forward the poorer ones. Even if a good man is not driven out he will finally be reduced to

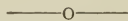
the level of the others and the whole body of surgeons will degenerate. It may be objected that the unqualified man will be held back by his results. That would be true if he had no ability at all. Some ability is necessary to get along even under the present conditions. It is not difficult however to remove a nonadherent appendix or do a ventral fixation of the womb. Diagnosis will not give much trouble if one waits to open the belly first. These cases compose a very large part of the surgery one is called upon to do and an agreeable man may escape criticism with very modest qualifications. These easy requirements for a surgeon have increased the number enormously. A large proportion of the men in bigger towns are professing to be surgeons. So many, that they cannot make a living in the specialty alone, but are compelled to take any sort of cases they can get. We hear a great deal of overspecialization but the time will hardly come when surgery alone is not a sufficient field for any one man. One cannot exhaust the possibilities of surgery and be at the same time a G. U. man and an obstetrician. So it might be in order for us to ask whether some of this expected degeneration of the surgeons of the state has not come already. This can be answered only as a matter of opinion. Certainly the consensus of opinion in our part of the state is that conditions could be much better. Numbers of cases could be reported that would indicate this if space would permit. We get a partial confession from some surgeons already when they say that they do not claim much ability in diagnosis. Diagnosis is what costs us effort. It is diagnosis that tests our ability and mainly determines our results. The surgeon without a diagnosis is a butcher and the medical man a poisoner. Above all things a surgeon should know what he is cutting for and when to cut. The readiness with which some surgeons decide to operate is a great reflection on the profession as well as the promptness with which some general practitioners advise it. When a patient is told that he will die if he is not operated and fails to do so promptly he and his whole family are lost to the irregulars. The word operation should be used with great caution after the most careful diagnosis.

Another very important effect of fee-splitting is that it unfits a man to take a courageous stand on any question. The man who must discuss his own conduct in whispers is not likely to be a relentless follower of quacks and criminal practitioners. There are men holding high positions in the society and at the same time performing operations for open advertising quacks. There are a great many better men who deplore this, but their hands are tied by the consciousness of their own failings.

The loss of public confidence is another result to which this underhand way of dealing contributes. People are beginning to know of it through the newspapers and magazines. The poor layman without the advantage of medical ethics may not be able to see the difference between dividing fees in secret and advertising in the newspapers. He knows that in business newspaper advertising is legitimate and proper, while the taking of secret commissions is a crime before the law. He might even go so far wrong as to accuse our worthy ethical surgeons of advertising among the general practitioners.

If allowed to go on this condition of affairs will finally correct itself. As people learn it of they will go directly to the surgeon and escape the general practitioners commission. Some surgeons are taking advantage of this already and beginning with the general practitioner they worm their way into his practice and bid directly to the people with the lower fee. It is said that in one city these men will do a major operation for \$25.00. It might seem that this would be a good thing for the people, but considering the serious nature of an operation, it is doubtful if one can afford to economize to that extent. A man who will work for so small a price will hardly qualify himself or give the patient the strict attention essential to the best results. Besides, when a patient goes away for an operation he needs someone who has a personal interest in him and whose reputation will suffer a little if he does not return alive. We have had some knowledge of people who go away alone seeking operation. They always get it whether they need it or not. So it seems that people cannot afford to ignore their family physician at such times but his care is just as necessary as in any serious disease. What is needed then for the benefit of everybody concerned is a better understanding between the patient, the family physician and the surgeon. The ethics of the profession should be observed in surgical cases the same as others. When a surgeon is called upon to take a case he should insist upon calling the man previously in attendance if possible. The attending physician should go with his patient to the hospital and let the family understand that the consultation is important and is to be paid for accordingly. There is no better post-graduate course than to follow one's case to the operating table and there verify or correct the diagnosis. The people will be ready to pay for the general practitioners services when they have been taught the value of them. As long as he offers to go with a patient to the hospital for his expenses, they will never understand it. In the country we have had some experience in telling patients frankly

that we deserved a relatively large fee for giving special study to a surgical case and assisting at an operation and they have always supported us cheerfully. The secrecy is unnecessary. It is maintained for the benefit of a few unscrupulous men who want to do surgery. The rest of the profession lose by it. I have not touched upon the moral nature of this fault. There is not so much wrong as misunderstanding. Most men engaged in this practice are the victims of circumstances and think they are compelled to it in order to make a living. The results though on the whole are disastrous. Laws and society regulations will not correct this evil but only serve to conceal it. It must be corrected by a more complete co-operation of the men in all branches of medical practice. This co-operation is needed at this time for a number of other reasons. Quacks of the most arrant kind are hiding under the cloak of the medical profession. Irregulars are becoming bolder and gaining ground with the people. The fact that many intelligent people are abandoning the regular profession for systems of healing which depend only on nature for their results is a strong criticism of the way the science of medicine is applied in this state. If we do not get results in sufficient proportions of cases to impress the people it is our fault. In a general way the people arrive at the truth. The way to deal with irregulars is not by criticisms which are often illogical, or by state legislation, but by showing the people that we are a hard working, honest body who have an interest in them and faith in our profession, and the question of irregulars will be solved. What the medical profession needs is a great cleaning-up and that cleaning up should start from the inside.



If the extremities of the stocking, drawer-leg, stockinette or flannel bandage put next to the skin when a plaster cast is to be applied are turned down over the cast and then a few turns of the plaster bandage are made over them near but not at the edge of the cast, a neat and comfortable cuff or margin will thus be provided

To account for a chill and pyrexia in a post-operative or post-partum course exclude pneumonia and pyogenic infection before considering malaria. On the other hand, of course, malarial recrudescences are sometimes precipitated by operation and by parturition; and too, it is important to bear in mind that malarial seizures are occasionally marked by vomiting and localized pain and tenderness in the appendix region, easily leading to a mistaken diagnosis.—American Journal Surgery.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903; Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr. H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

If you wish this Journal to become self-supporting, then at every opportunity give the advertisers your preference. You can depend on the pharmaceuticals advertised in the Journal, because to be there, they have to be approved by the Council on Pharmacy and Chemistry of the A. M. A. Therefore they are dependable. If you will remember that the editor wants a little help in this particular, it will be mutually advantageous.

—O—

Every medical college should teach in its department of materia medica and therapeutics, the constituents of proprietary preparation. The advantages would be many. The students would then learn by precept rather than by experience later, the types of innocuous and also dangerous compounds, and be able to select such as are of value. The text-book should be the report of the council on pharmacy and chemistry of the American Medical Association.

It is to be hoped that the day is not far distant when proprietary preparations without value will be a "*drug on the market*," without demand and this plan would be a helpful way to that end.

—O—

The annual meeting of the American Medical Association at

Minneapolis June 17-20, promises to be one of unusual merit. The scientific sections are well filled with papers by leaders in the profession and the social side is well filled with entertainments for both doctors and their wives. The meetings are to be held on the grounds of the University of Minnesota, situated midway between Minneapolis and St. Paul, so that it will be convenient to have hotel accommodations at either place. One can hardly afford to miss the opportunity of combining this profitable trip with a summer vacation. The Burlington will run a special train to Minneapolis for the benefit of the profession of Kansas. It will leave Kansas City, Mo., at 4 p. m., Monday, June 16th, arriving at Minneapolis the next morning at 8.

—o—

PROCEEDINGS OF THE FORTY-SEVENTH ANNUAL MEETING OF THE KANSAS MEDICAL SOCIETY.

MEETING OF THE COUNCIL.

Topeka, Kansas, May 6, 1913.

The Council of the Kansas Medical Society convened on the above named date with Dr. Geo. M. Gray, president, in the chair. Those present were: Chas. S. Huffman, secretary, councillors: W. E. McVey, Wm. F. Fee, H. B. Caffey, C. S. Kenney and A. D. Jones. Several other councillors came in later to the meeting.

After some discussion relative to the appeal of Dr. Shelton of the Montgomery County Medical Society, it was decided to lay the matter over until some future time.

An Auditing Committee was appointed, consisting of Dr. W. F. Sawhill and Dr. A. D. Jones.

Dr. J. W. May, Editor of The Journal, made his report, which was as follows:

To The Kansas Medical Society:

Gentlemen—Your editor begs leave to submit the following report for the year ending May 1, 1913. First as to the financial condition.

The receipts from advertising were.....	\$1,525.20
Amount received from state society.....	1,000.00

Total.....	\$2,525.20
------------	------------

Amount paid out as follows:

12 issues of Journal at \$105.00.....	\$1,260.00
Postage.....	64.38
Envelope wrappers, Journal.....	60.00

Cuts and inserts.....	8.50
Re-copying articles and mailing.....	40.20
Editors salary.....	1,000.00
<hr/>	
Total.....	\$2,433.08
Substracting expenses.....	\$2,433.08
from the receipts.....	2,525.20
leaves a balance to be returned to state society of	92.12
There is now on the books to be collected.....	98.00

At the meeting of the Council, held one year ago, I was instructed to remove all advertising from the Journal not approved by the Council on Pharmacy and Chemistry of the American Medical Association. This was done and it resulted in a direct monetary loss of three hundred dollars, and a refusal of more than that amount in new advertising. However, we have secured some new business, which practically made up the deficiency. Any loss we have sustained by refusing advertising of doubtful character was money well spent for I am happy to say that our Journal stands today as clean in its advertising pages as the Journal of the American Medical Association and many letters have been received commending us for the stand we have taken. Our prospects for the next year are brighter than ever.

As to the reading pages of The Journal, I believe that there has been greatly increased interest, due to a discussion by the Councillors, who are associate editors, of questions of paramount interest to the society and to the public in general. There has been a ready response to requests for editorials from the councilors and I believe interest can be increased in the future from this source if more space is used by the associate editors.

The "News Notes" department is not as hard to fill as before your help was given, but now does not contain one-tenth what it should. If county secretaries could be induced to act as reporters it would then be possible to have a much more readable Journal.

In conclusion I desire to thank you for the help given and the kindly interest shown the Journal and hope for a continuance of the same. Also that you overlook the unfortunate incident of last November, when the Journal came out so strongly for one of the gubernatorial candidates. This, however, was not done until he had given positive assurance that if he were successful he would not permit any vicious medical legislation to be enacted without exercising his power of veto. You all know the result.

JAMES W. MAY.

Motion was made that the action of the council in regard to Dr. Shelton, be expunged from the records.

Council adjourned to meet at the call of the president.

MEETING OF THE HOUSE OF DELEGATES.

Topeka, Kansas, May 7, 1913.

House called to order by the president, Dr. Geo. M. Gray. Roll of delegates called, and a quorum was found to be present. The first business considered was the report of the officers.

SECRETARY'S REPORT.

During the past year many events of striking interest have happened, relating to the medical profession.

First, will say that our state society is in good condition, taking the state as a whole. There has been more interest shown in the county and district societies than ever before. Better programs have been prepared, and better attendance recorded. Our state organization remains about the same as last year. While we have many new members, many of the old members have left the state, taking with them transfer cards. I certainly wish to commend the work done by many of the officers and members of the local county societies. If time and space would permit, I would be glad to give the names and kind of work done by each member.

We have tried to keep in touch with the work done by the American Medical Association, and its numerous sub-committees, as well as with other organizations throughout the United States. We have worked in harmony with our state board of health, and gave them all the assistance possible, in carrying on their splendid work, also have done all we could toward increasing the usefulness of our medical school at Rosedale, an institution which we ought to foster and help in every way possible. Our state society should be a unit in the support of the state institutions.

Will say secondly, that on the other hand we have met some reverses. This being the year in which the legislature met, that body did much that directly effects the medical profession. It is not necessary for me to mention the chiropractor law, osteopath board, and the onslaught made on the state board of health. The feeling in the legislature against the doctors and medical profession

in general was bitter and intense. I often asked myself the question, why? What brought about this antagonism? Is the medical profession itself to blame for the condition? I sometimes think we are at fault, and especially so, when I recall the fact that the chiropractors presented a petition with twenty thousand names on it, for the passage of the bill, and only twelve members of the Kansas Medical Society asked the Governor to veto the chiropractors measure. What were the twenty-eight hundred members of our profession doing all this time? It is time that we should awaken and take some interest in things that effect us so vitally as the legislation enacted this year.

On this date we have 1050 members who have paid their dues up to date. Our financial condition is as follows:

In 1911, \$2,000.00 was taken from the general fund and placed in the medical defense fund. Of this amount \$150.00 was spent last year, leaving a balance of \$1,850.00.

In 1912, \$1,000.00 more was transferred to the medical defense fund, and also \$340.00, which was twenty-five cents per capita on all the paid up membership, making a total of \$3,190.00 in the medical defense fund for 1912.

May 3, 1912—Balance on hand medical defense fund \$3,190.00

May 6, 1913—Amount received 25 cents per capita . . . 260.00

Total \$3,450.00

AMOUNT PAID OUT.

June 9, 1912—No. 1	\$ 98.54
June 27, 1912—No. 2	100.00
June 27, 1912—No. 3	50.00
July 2, 1912—No. 4	150.00
July 2, 1912—No. 5	100.00
Oct. 23, 1912—No. 6	107.40
Dec. 14, 1912—No. 7	100.00
Dec. 14, 1912—No. 8	39.86
Feb. 1, 1913—No. 9	50.00
Mar. 20, 1913—No. 10	100.00
April 24, 1913—No. 11	100.00

Total \$ 995.80

Balance on hand Medical Defense Fund 1,254.20

May 3, 1912—Balance on hand General Fund \$2,886.89

May 6, 1912—Amount received for dues less \$260. 1,827.00

May 6, 1913—Amount received from Dr. May (Journal) . .	103.67
May 6, 1913—Interest on Harper Loan	110.00
Total	<u>\$1,927.56</u>

Respectfully submitted,
CHAS. S. HUFFMAN, Secretary.

AMOUNT PAID OUT.

May	2, 1912—No. 1	\$ 17.00
May	2, 1912—No. 2	59.25
May	2, 1912—No. 3	35.00
May	2, 1912—No. 4	490.00
May	2, 1912—No. 5	9.56
May	2, 1912—No. 6	3.90
May	2, 1912—No. 7	8.30
May	2, 1912—No. 8	260.00
May	25, 1912—No. 9	1000.00
June	8, 1912—No. 10	7.60
June	8, 1912—No. 11	2.00
June	12, 1912—No. 12	3.50
June	13, 1912—No. 13	80.00
July	12, 1912—No. 14	29.85
July	12, 1912—No. 15	8.00
Oct.	4, 1912—No. 15	5.75
Oct.	18, 1912—No. 16	2.50
Nov.	9, 1912—No. 19	3.75
Dec.	14, 1912—No. 18	7.25
Jan.	6, 1913—No. 19	7.50
Jan.	20, 1913—No. 20	32.65
Jan.	21, 1913—No. 21	39.38
Jan.	20, 1913—No. 22	34.89
Feb.	1, 1913—No. 23	35.15
Feb.	1, 1913—No. 24	21.65
Feb.	1, 1913—No. 25	50.00
Feb.	1, 1913—No. 26	50.00
Mar.	20, 1913—No. 27	323.80
Mar.	20, 1913—No. 28	320.62

Total	<u>\$2,948.85</u>
Balance on hand in General Fund	1,978.71
Balance on hand in Medical Defense Fund	2,454.20
Total amount on hand	<u>\$4,432.91</u>

TREASURER'S REPORT.

Mr. President and Fellows of the House of Delegates:

I have the honor to submit the following report:

Cash on hand May 1, 1912.....	\$ 6077.89
Cash received on Harper interest.....	110.00
Cash received from our secretary.....	2190.67

Total.....	\$8378.56
------------	-----------

Cash paid out by order of president and secretary.....	\$ 2948.85
--	------------

Cash paid out vouchers countersigned by Chairman of Medical Defense Committee..	995.80
---	--------

Total.....	3944.65
------------	---------

Cash on hand May 6, 1913, subject to check and mortgage.....	4433.91
--	---------

Respectfully,

L. H. MUNN, Treasurer.

REPORT OF COMMITTEE ON MEDICAL DEFENSE.

House of Delegates Kansas Medical Society:—

I beg leave to report for the Medical Defense Board as follows: Since the Defense Fund was created in May, 1911, we have had formal applications and assisted in the defense of eleven suits for mal-practice. Five of these have been dismissed or settled and six are still pending. The cases in which we have assisted are as follows:

(1) W. W. Bowman vs. Dr. A. M. Dawson, Topeka, Shawnee County Society, suit for damages for mal-practice in treatment of hand. Suit dismissed.

(2) Mabel Stanley vs. Dr. M. T. Billingslee, Altoona, Wilson County Society, Judgment \$25.00.

(3) Gill vs. Dr. Z. Nason, Kansas City, Wyandotte County Society. Suit for mal-practice. Dismissed. Effort to revive suit.

(4) Kittie Meadows vs. Drs. J. L. Work and J. G. Stewart, Topeka, Shawnee County Society. Mal-practice suit dismissed.

(5) J. C. Woolry vs. Dr. R. R. Nevitt, Mildred, Allen County Society. Suit for mal-practice in treatment of injury. Dismissed.

(6) C. H. George vs. Dr. L. W. Shannon, Hiawatha, Brown County Society. Suit for damages resulting from X-ray burn. Pending.

(7) Frank J. Tetlinski vs. Dr. W. F. Fairbanks, Kansas City, Wyandotte County Society. Mal-practice in treatment of fracture of forearm. Pending.

(8) Josephine Cummiskey vs. Dr. R. M. Markham, Scammon, Cherokee County Society. Suit for malpractice in treatment of fracture of arm. Dr. Markham having already made contract with attorneys at a much larger fee than we thought justifiable we offered to pay \$200.00 on the attorney fee.

(9) S. P. Green vs. Dr. Chas. S. Huffman, Columbus, Cherokee County Society. Suit for damages in mistreatment of fractured hip. Pending. Dr. Huffman saw the case once in consultation.

(10) S. P. Green vs. Dr. W. N. Johnson, Columbus, Cherokee County Society. Suit for damages for mistreatment of fractured hip.

(11) Mary A. Brooks vs. Dr. J. A. Davis, Kansas City, Wyandotte County Society. Suit for damages for mistreatment of fracture of arm.

The most serious difficulty met by the board has arisen from the fact that most all of the applicants for assistance in defense of these suits have already engaged attorneys, and in some instances the fees have been rather higher than was necessary. The board decided therefore that no contract of this kind would be assumed, but that we would select an attorney to take charge of the defense in all cases in which we were asked to assist. The board therefore in order to be able to keep more closely in touch with the cases made a contract with attorney, E. D. McKeever, to take charge of all cases for one year beginning January, 1913.

The status of the Defense Fund is as follows:

Amount set aside by amendment to constitution.....	\$2000.00
Amount per capita to May 1, 1912.....	340.00
Amount added to fund May 1, 1912.....	1000.00
	<hr/>
	\$3340.00
Amount paid out on warrants to date.....	\$ 995.80
Balance remaining in fund.....	2344.20
Amount due on contracts outstanding.....	750.00
	<hr/>
Amount available for future cases.....	\$1594.20

Respectfully submitted,

W. E. McVEY, Chairman.

REPORT OF AUDITING COMMITTEE.

We, your Auditing Committee, have examined the vouchers,

stubs and bills, and find the reports as made by the officers to be correct.

ARCH D. JONES,
W. F. SAWHILL, Committee.

May 1, 1913.

REPORTS OF COUNCILLORS.

To the Officers and Members of The Kansas Medical Society:—

As Councillor for the First District, I beg to submit the following report.

Of the eight counties in my district, all are organized. Atchinson and Marshall counties had lapsed, but have recently been organized. Doniphan, Washington and Jefferson counties have kept their societies in good standing, but have had held meetings very irregularly. Brown, Neosho and Jackson counties have flourishing societies and meet quite regularly, and as a rule, have enthusiastic meetings. As to the exact number of members in each society, I am not informed, except in my own society (Jackson) which has twenty-one out of twenty-four eligible physicians. As a whole, I believe the First District is in the best condition it has been in for five years. During last summer Jackson County Society arranged for a public meeting in one of the largest churches in Holton. The meeting was held on Sunday afternoon, and addressed by a representative of the American Medical Association, his subject was "The Great Black Plague" or "The White Slave Traffic". We had a very large attendance, and I believe much good resulted.

Respectfully,
C. W. REYNOLDS, Councillor.

To the President and Members of the Council:—

I have the pleasure to report my District in a flourishing condition. Every county in our district has a good society and with one or two exceptions, no friction exists.

In Woodson County there has been an appeal in the case of one of the physicians who desires to become a member of the State Society, but refuses to make application through his County Society.

In Montgomery County, one of the physicians has been denied membership for the second time, and he is appealing to this body, and the matter will be explained in detail, at another meeting of the Council. The District Society met at Pittsburg, in September, and again in Parsons, in April. Both meetings were attended by about seventy-five members, and every county in the dis-

trict was represented. The next meeting will be held in Chanute in September.

HUGH B. CAFFEY, Councillor.

Report of Councillor of the Fifth District:—

One important duty of each Councillor is to attend every meeting of the Councillors and all meetings of the State Society. No Councillor can know of the workings of the society unless he has done this. The looking after the interests of the whole society falls largely upon the councillors. The publishing of the Journal, arrangement of programs, choosing places for the meetings, looking after legislation, and many other matters of general interest of the society. The Medical Defense of the members is no small task for the councillors, and if properly handled will surely build up the membership of the society.

We have organized the Southwest Medical Society, recently, to meet at Hutchinson, twice yearly, thus bringing us in contact with many of the physicians of the Southwest, who have no county organizations.

W. E. CURRIE, Councillor.

Report of the Sixth District:—

This District composed of nine counties, all of which are organized and holding regular active meetings. Have heard by correspondence or personal report from all of them. Visited Ellis county at Howard meeting, July 24, 1912. They had at that time an excellent meeting with plenty of program and case reports. Consider it one of the best in the district. Sedgwick county now has its own meeting place. Has purchased a balopticon at expense of \$380.00. Meets every Tuesday evening. Finds the balopticon a very useful and interesting instrument. Most of the counties report a stationary membership, practically. Occasionally a new member coming into county. The reason for this is that nearly every man is already a member.

The matter of quarantine is receiving rather active attention on account of so many who have contagious diseases in so mild a form that they do not call a physician. The few who do, are quarantined, to their minds, unjustly. This is a matter for lively discussion which seems to bring itself to no solution.

I would say that my District is very much alive in every respect. We acknowledge our share in the election of the present Governor.

ARCH D. JONES, Councillor.

To the Council of the Kansas Medical Society:—

Gentlemen—During the past year I have pursued the same plan as reported one year ago. I have found it impossible to maintain separate county organizations in all the counties in my district. At present the counties of Ellsworth, Russell and Ellis have combined in one society; the Central Kansas Medical Society. This society is in a flourishing condition, and includes in its membership practically all the physicians located along the main line of the U. P. railroad.

The Saline County Medical Society during the past year held monthly meetings, with the exception of July and August. These meetings were interesting and well attended, and included not only the physicians of Saline County, but also the physicians of Ottawa and Lincoln Counties. One meeting was held in Minneapolis and one in Gypsum, during the year. All other meetings were held in Salina.

Respectfully submitted,
O. D. WALKER, Councillor.

Mr. President and Members of the House of Delegates:—

As Councillor of the Ninth District, comprising the counties of Cheyenne, Rawlins, Decatur, Norton, Phillips and Smith, I beg to report that every county has been organized, but there are but two active societies, the Smith and Decatur-Norton County societies. It is very difficult to get out the members in Cheyenne and Rawlins Counties, owing to the small number of members. In Phillips County there are a sufficient number of active physicians to make a good society, but I have never been able to get them together. Not having had an opportunity to meet with them I am not in position to state just what the difficulty really is.

Last winter the Ninth and Tenth Councillor Districts met and organized a District organization, with Dr. F. H. Smith of Goodland, President and C. W. Cole of Norton, secretary. The society will meet annually in October, at Norton. The plan in this district is to have public addresses on public health matters and we note some good resulting from this practice.

Conditions are not what is desired in this district, yet with two active societies, there are a number of good meetings each year and the scientific programs are made very interesting at each session.

C. S. KENNEY, Councillor.

The report of the Seventh District for the past year is not so

good as it should be, yet there is so much improvement in the past ten years, that it marks upward progress. There are twenty-nine physicians of all kinds in Cloud County. Of that number, some of course, are ineligible, but we have nineteen in good standing in the medical society. There has been four meetings held during the past year, all well attended and good papers read with very interesting discussions. The Mitchell County Society has held four meetings during the year, two at Beloit, and two at Glen Elder. It has gained one member and lost three. Osborne County Society had three meetings during the year, and has eleven members in good standing. I was unable to get a report from Rooks County. Jewell County has a medical society, but did not have any meetings during the year. Republic County Medical Society has been the most aggressive of any in the District. At their annual meeting, in November, 1912, Dr. Van Camp was elected president, Dr. C. V. Haggman, vice-president and Dr. H. D. Thomas, secretary and treasurer. They decided to have a public lecture, and secured Dr. W. W. Grant of Denver, a director of the A. M. A., This address was delivered April 15th. The public were admitted and were much pleased, as it was very instructive. They are planning to have another address this fall and also to extend the work to the rural schools. We are hoping that we can soon have a series of lectures in the Seventh District.

There is one thing that exists in this district more or less, and I suppose does in all, that is to be deplored, and that is the commercializing of the medical profession. Medical ethics is certainly not so well taught as formerly in our medical schools, as the younger graduates are as a rule, the worst offenders. The physician who follows our code of ethics, soon looks upon the practice of medicine as a profession, not a business. My purpose in saying this is, that I believe this commercialism more than anything else directs the profession into gangs and increases the difficulty of maintaining a county society.

Respectfully,

W. F. SAWHILL, Councillor.

An amendment was offered to the constitution as follows: Amendment Article 11, Section 2, by changing the figures \$2.00 to \$3.00 per annum. This motion was laid over for one day.

It was moved that a committee be appointed to select some suitable design or button for a badge, to represent the Kansas Medical Society. The chairman appointed Dr. W. E. McVey and Dr. O. P. Davis as members of this committee.

The House of Delegates adjourned until 8:30 a. m., Thursday.

MEETING OF THE HOUSE OF DELEGATES.

Topeka, Kansas, May 8, 1913.

Meeting was called to order at 8:30 a. m., with Dr. Geo. M. Gray, president in the chair. Roll of delegates was called, and a quorum was found to be present.

Several ladies, representing the Crittendon Home at Topeka, requested that they be allowed to address the meeting and on motion they were permitted to do so. It was also moved and seconded that a free advertisement of this Institution be carried in the Journal for one year.

A communication was read from the secretary of the Medical Association of the Southwest, and in compliance with this request, the following resolution was introduced and apoted.

Whereas, A Medical Association known as the Medical Association of the Southwest, composed of the physicians residing in the states of Kansas, Oklahoma, Arkansas, Missouri and Texas, and

Whereas, This society is entitled to recognition by the A. M. A., therefore be it

Resolved, That it is the sense of the Kansas Medical Society that the Medical Association of the Southwest be recognized and affiliated with the A. M. A., and it hereby authorizes such action.

At the general session of May 7th, Dr. C. C. Nesselrode introduced the following resolution:

Resolved, That the President of this society this day, appoint a committee of five, to be known as a committee on Public Health and Education, to work in conjunction with the Committee of the A. M. A., of like name. This committee to work under the direction of this society and its council in furthering the knowledge of preventative medicine, and especially a knowledge of cancer, and the importance of an early diagnosis among the lay public.

In compliance with the above resolution, the president appointed the following committee: Dr. C. C. Nesselrode, Kansas City; Dr. M. Trueheart, Sterling; Dr. T. A. Jones, Liberal; Dr. M. T. Sudler, Lawrence and Dr. O. D. Walker, Salina.

An amendment introduced on the previous day, amending the constitution, article 11, section 2, by changing the figures \$2.00 per annum to \$3.00 per annum. Adopted by a unanimous vote.

The following officers were elected for the ensuing year:

President, Dr. M. F. Jarrett, Ft. Scott; 1st vice-president, Dr. C. C. Nesselrode, Kansas City; 2nd vice-president, Dr. J. F. Gsell, Wichita; 3rd vice-president, Dr. G. A. Blasdel, Garnett; Treasurer, Dr. L. H. Munn, Topeka. Delegate to A. M. A., Dr. Geo. M. Gray, Kansas City.

Councillor Third District—Dr. H. B. Caffey, Pittsburg, 3 years.

Councillor Sixth District—Dr. A. D. Jones, Wichita, 3 years.

Councillor Tenth District—Dr. R. D. Stoner, Quinter, 3 years.

Councillor Eleventh District—Dr. J. A. Dillon, Larned, 3 years.

Councillor Twelfth District—Dr. W. F. Fee, Meade, 3 years.

The following Councillors hold over:—

First District—Dr. C. W. Reynolds, Holton, term expires 1914.

Second District—Dr. C. C. Goddard, Leavenworth, term expires 1914.

Fourth District—Dr. W. E. McVey, Topeka, term expires 1914.

Fifth District—Dr. W. E. Currie, Sterling, term expires 1914.

Seventh District—Dr. W. F. Sawhill, Concordia, term expires 1915.

Eighth District—Dr. O. D. Walker, Salina; term expires 1915.

Ninth District—Dr. C. S. Kenney, Norton; term expires 1915.

The following members of the Medical Defense Board was elected:

Dr. W. E. Currie, Sterling, for 3 years.

Dr. O. D. Walker, Salina, term expires 1915.

Dr. W. E. McVey, Topeka, term expires 1914.

Wichita was selected as the next place of meeting. Date of next meeting was left for the Council to determine upon.

The appeal from the Montgomery County Medical Society, in not accepting Dr. F. W. Shelton as a member, was next considered. Motion was made and prevailed, that the matter be referred back to the Montgomery County Medical Society, with the recommendation that this society give its reason, if such reasons are known, to the County Medical Society; to Dr. Shelton. In case this does not adjust the matter in controversy, in a satisfactory manner, then send to the Council more definite information.

Dr. A. D. Jones, Councillor of the Sixth District, stated that Dr. A. D. Updegraff of Harper County, had moved to Sedgwick County and wished to join by application instead of a card. The Censors refused to recommend his application. Dr. Jones requested that the House of Delegates take some action on this.

Motion was made that the Council of the State Medical Society confer with the Sedgwick County Medical Society, in regard to Dr. A. D. Updegraff, and recommend that he be not taken into the society. Also recommended that his card be dropped from the Journal, until the time when the matter could be adjusted, and if any money was due him for advertising, it be returned to him. Moved and seconded that the House of Delegates adjourn.

The scientific part of the program was carried out to the letter. Many interesting and valuable papers were read and discussed.

There was a large attendance at all times. This meeting was one of the most successful in the history of the Kansas Medical Society.

Respectfully,

CHAS. S. HUFFMAN, Secretary.

—O—

SOCIETY NOTES.

EIGHTH ANNUAL MEETING OF THE MEDICAL ASSOCIATION OF THE SOUTHWEST TO BE HELD AT KANSAS CITY, OCT. 7-8.

Plans are being rapidly formulated for the coming meeting of the Medical Association of the Southwest to be held at Kansas City in October. While the section officers are confident of presenting an unusually strong program, this will be but one of the important features of the meeting; the committee are preparing a schedule of the clinics in all the hospitals and institutions of the city which will begin Monday morning and continue until Saturday afternoon. There will of course be no clinics held on Tuesday and Wednesday as these days will be given up entirely to the scientific program.

These clinics are to be held for the general practitioner rather than simply for the specialist, that is; clinics in general medicine will be held rather than simply the surgical and other special branches.

An added attraction at this time will be the presence of Dr. J. A. Witherspoon, president of the A. M. A., who is to be our guest of honor.

Kansas City always does herself proud in the matter of entertaining her visitors so that does not even need to be mentioned as it will be understood that every thing will be looked after that can enter into those attending having a fine time.

If possible special railroad rates will be arranged for, but the results of the effort put forth in this direction in the past do not promise much in that direction this year.

There is still room for a number of papers on the program and a cordial invitation is extended to those who wish to present one to do so. If you wish to accept this invitation, please be prompt and send your name and the title of your paper to F. H. Clark, M. D. Secretary, El. Reno, Oklahoma.

—O—

The McPherson County Medical Society was organized at McPherson May 2nd. The following officers were elected: President, Dr. I. A. Bradbury, Galva; secretary, Dr. G. R. Dean, McPherson.

The Atchison County Medical Society was re-organized at Atchison, May 5th. The following officers were elected: President, Dr. M. T. Dingess; secretary, Dr. E. T. Shelly both of Atchison.

—o—

The Seventh District Medical Society was organized at Hutchinson April 24th. Dr. S. M. Colladay was elected president and Dr. W. F. Schoor secretary. Both live in Hutchinson.

—o—

At the annual meeting of the Marshall County Medical Society held at Marysville, April 29th, Dr. W. E. Ham of Beattie was elected president and Dr. Jennie L. E. Eddy of Marysville, secretary.

—o—

The Brown County Medical Society at its annual meeting held at Hiawatha, April 8, elected Dr. H. J. Harker of Horton, president.

—o—

NEWS NOTES

The Kansas State Board of Medical Examination and Registration will hold its next examination meeting at Topeka, June 10th. Dr. H. A. Dykes of Lebanon, is the secretary.

—o—

Dr. David C. Dodds of Summerfield, was married April 30th, to Miss Hilda Wolking of Albuquerque.

—o—

Camp to Remain—The Tuberculosis camp at North Topeka, is to be allowed to remain where it is, pending definite arrangements for a permanent home.

—o—

Drs. H. S. Kickok, W. H. Carter, W. P. Greening, G. K. Purves and H. H. Taggart, have been elected members of the staff of Wesley Hospital, Wichita.

—o—

Drs. Arch D. Jones and Martin Hagar have been reappointed members of the Wichita Board of Health.

—o—

Dr. and Mrs. Virgil W. McCarty of Rosedale, sailed for Europe April 26th. Dr. McCarty will do post-graduate work for twelve months.

—o—

THIRD DISTRICT.

Every county of the Third District was represented at the

state society meeting except Neosho and Woodson.

We of the Third District are proud of our new president, Dr. M. F. Jarrett of Fort Scott, and his election throws this District into the lime-light for the whole state for the ensuing year. We must make good by giving him our support and encouragement and this can be no better accomplished than by regular meetings of all the county societies and by getting every eligible man in the District to become a member.

Every thinking man of the society will welcome the raise of one dollar in the annual dues, when he stops to consider that it strengthens the organization and more securely protects him from viscous mal-practice suits.

Dr. H. H. Bogle of Pittsburg, will be absent ten days attending the Presbyterian Pentecost at Atlanta, Georgia. Mrs. Bogle accompanied him.

The Crawford County Medical Society was represented at the State Society meeting by Drs. C. R. Tinder of Arcadia, and F. A. Harper and H. B. Caffey of Pittsburg.

Dr. E. I. Parmenter of Mineral is at the bedside of his wife in a Kansas City Hospital. She is reported to be seriously ill.

Dr. and Mrs. R. B. Gibb of Pittsburg, have recently returned from a visit to Texas and Arkansas.

Drs. R. Claude Lowdermilk and Lee Baxter were "amongst those present" from Cherokee County at the Topeka meeting.

OBITUARY.

Abel S. Cloud, M. D., University of Louisville, Ky., 1868; of Kiowa; a member of the Kansas Medical Society; died at the home of his son in Cherokee, Kan., about May 2.

REVIEWS.

Treatment of Placenta Previa with Hypophyseal Extracts.—By Trapl (Monatschr. f. Geburtsh u. Gynak., October, 1912.)

Trapl reports an experience with sixteen cases of placenta

previa treated with pituitrin, among which subsequent labors were favorable for the mother and in only one case did an atonic condition of the uterus develop. Thirteen living children were born, of which two died subsequently of inanition. Three children were born dead, two of which were found to have died before the pituitrin was employed. Out of the fourteen cases in which the children were alive, there were three cases of marginal, ten of lateral and one of central placenta previa. In one case where a fetal death resulted, this occurred four hours after the injection and it is doubtful therefore whether it was due to the same. The course of the labor was accelerated in the majority of the cases. The author's recommendation are as follows: If only a small portion of the placenta presents, and especially if a vertex is present and the labor has advanced to such an extent that the cervix is shortened and sufficiently open, then the membranes are ruptured and pituitrin given. This method is best adapted for those cases in which a marginal variety of placenta previa is present, because if a larger segment presents the engagement of the head is interfered with. In other cases the author recommends combined version with injections of pituitrin. The resulting labor pains force the breech against the loosened segment of the placenta, and the completion of the delivery may be safely awaited, no attempts at extraction being necessary except that directed to the arms and the head. In cases where dilatation is not sufficient to admit combined version, a small dilating bag may be inserted, or a vaginal tampon applied, after this becomes sufficiently dilated, then a combined version with injection of pituitrin follows.—The Post-Graduate.

—o—

The Treatment of Amenorrhea—Fromme (Zentralbl. f. Gyn.) mentions the cases in which this condition is present for prolonged periods without pregnancy. Thus far the treatment in such instances has been unsatisfactory, and in view of a possible disturbance of the internal secretory glands being at the bottom of the amenorrhea, Fromme suggested injection of hypophyseal extract. The writer employed doses of 1 cc. daily until a result was obtained or the method was found without effect after several weeks' trial. Of twelve cases thus treated five were without result, two were doubtful and five reacted promptly. He says that those patients are most suitable for this treatment in whom a well-marked adiposity is present and in whom disturbances of the internal secretions are most likely. In view of the uncertainty of the effect of these substances its further recommendation must, however, be held in abeyance.—Charlotte Medical Journal.

The Influence of the Automobile upon Obstetrical Conditions—Edgar (*American Journal Obstetrics*, June, 1911), has investigated the subject of the use of the motor car upon obstetric conditions. He believes it to be true that the motor car causes more vibration than any other vehicle; the distance traversed at one sitting is almost invariably greater with the motor car than with the horse-drawn vehicle, and the patient is almost unconsciously exposed to considerable strain. The effect of the motor car on the nervous and circulatory systems is very different from that produced by other vehicles. Some patients seem but little disturbed, even though high speed is used and long runs are made, and minor accidents on the road may occur. Such patients can usually be allowed to use a motor car during pregnancy, if very careful to avoid actual physical fatigue, and do not use the motor at times corresponding to the menstrual periods. Other patients are made intensely nervous and excited by the use of a motor car, with rapid pulse and often insomnia. The continuous use of motor car tends to produce constipation, and hemorrhoids are made worse by motoring. Pelvic or abdominal congestion or inflammation is made worse. Pyelitis and appendicitis are aggravated. Displacements of the uterus and subinvolution are also made worse. If the motor car be used immediately after abortion or labor, subinvolution may be caused and backward displacements aggravated. In many anemic women, who are too flabby to take exercise, the motor car has proved a positive benefit, and in cases where prompt treatment is necessary the motor car has undoubtedly assisted in the saving of life.—*American Journal Medical Sciences*.

—O—

The Real Value of Nutritive Enema—M. Ramon Oppelt Sans (*La valeur réelle des lavements alimentaires intestinaux*). Is it possible to nourish a patient with stricture of the esophagus or cancer of the stomach by nutritive enema and how long can we sustain life by this method? After recalling the experiments on absorption by the large intestine by water, crystalloids, nitrogenous bodies, sugar, and amids, the author cites the work of Diena, who under the direction of Prof. Morpurgo, has shown the influence of the molecular concentration of solutions of sodium chloride, glucose and urea on intestinal absorption. The conclusion of all this work is that it is impossible to sustain a patient by this method exclusively longer than eight or ten days. After this time the patient begins to show the evidence of intolerance and inanition. On account of these results the author has thought to employ the hypodermic method to feed this class of patients. He employs

sterilized oil of sesame, injecting 30, 50 or 100 grams, according to the case, into the gluteal region. This produces a slight raise of temperature which falls in about six hours: Fat embolism or any other accident has not been observed or met. These injections are repeated every second day and the amount increased or diminished according to the result. The author has in this manner supported many cases for six, eight or ten weeks by this method alone.—*Gazette Medicale de Paris.*

—o—

MISCELLANEOUS.

Concerning Doctors—The doctor is the first person we meet when we come into this world, and, unless we go out by accident or other unexpected summons, he is the last with us when we leave it. Such devotion is worthy of the highest praise, and that is often about all the doctor gets for it. Still, he keeps at it, because practice makes perfect, and a doctor without practice isn't worth much.

Who the first doctor was is not known, but he must have arrived shortly after the devil broke into the Garden, because before that there wasn't any need of him. In other words, a doctor is a matter of necessity. When you need him, oh, yes, but you do need him, and if he had the nerve to present his bill just after he had pulled you out of the hole—one of those holes, you know, with a marble top to it—you would be glad to pay any amount he might ask. But later you feel some different, and you charge him with graft when he charges you with a sum which would have seemed small enough when you thought you were going to lose it all. But this is to a considerable extent the doctor's fault because, he should never let a patient get well enough to feel frisky like that until the bill is paid. That is one reason why doctors so often need the money, and doctors have expenses to meet just as other people do, though they never have any doctor's bills to pay. This is owing to the fact that the ethics of the profession forbid one doctor from charging another for professional services. Right here comes in one of the greatest temptations a doctor is called upon to resist, to wit; repairing one until he is as good as new and getting nothing for it, when by quietly letting him drop out, he might not only get rid of a competitor, but secure much of his practice. But no instance is on record of any doctor doing this. Really, don't you know, doctors are not nearly as bad as people in debt to them say they are.

It is common talk—very common—that the doctor is in league

with the undertaker, and that you might as well begin to pack up for the long journey when the doctor comes around. But plain business sense controverts this fallacy. "Live and let live," is the doctor's motto. *De mortuis non payabus*, which, being translated, means, "The dead ones don't pay." True, some of the live ones don't, but some do, and never a dead ones does. A graveyard may mean something to an undertaker, but it doesn't to a doctor.'

There are nearly as many kinds of doctors as there are varieties of professors of religion and politics. For example, allopaths, homœopaths, hydropaths, milkopaths, restopaths, and mentalo-paths, electropaths, osteopaths, arœopaths, prayeropaths, quackopaths, and numerous other paths, all going different directions, but all leading to the same destination: the cure of the ills that flesh is heir to. So Protestant, Catholic, Mohammedan, Jew, Buddhist, and the rest of them, all go differently, but all headed for heaven; Democrat, Republican, Socialist, Prohibitionist, Populist, Progressive, each taking a different way, but all headed for the pie-counter. Man is fearfully and wonderfully made. If he were not, the doctor's wouldn't have half the trouble with him they now do getting him started and keeping him going.

There are also women doctors. Women never have had any difficulty getting into religion, but getting into medicine and politics is quite another matter, and even in this day of phenomenal human progress, women doctors and women politicians are looked upon with more or less suspicion. They have got far enough along in medicine to have "Dr." prefixed to their names, but not far enough along in politics to prefix "Hon." yet. Note, please, that there is a strong accent on the "yet" in that sentence.

In conclusion, it may be stated, without fear of successful contradiction, that while there has been wonderful progress made in all branches of medical sciences and practice, mankind goes on dying about as usual, and if the dead were as greedy as the living are in grasping as much of the earth as they can get hold of, there wouldn't be any room for the live ones.—W. J. Lampton in *March Lippincott's*.

—o—

The Future of Preventive Medicine—Preventive medicine is capable, in the future, of doing away with poverty and misery, of remedying industrial disputes and of contributing to the cause of international peace. . . . It is capable of removing those causes of human misery, poverty and sorrow which lead to internal rebellion and disorder and, among nations, to war and strife. . . . We are going to get, through preventive medi-

cine, relief from the frictions which arises out of immigration among the leading nations of the world.—Charles W. Eliot.

CLINICAL NOTES

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL SURGERY.

If a sepsis of unknown origin is associated with a positive blood culture, don't fail to examine the ears. Sinus involvement from otitis media may be present with little objective evidence and no other symptoms than fever and chills.

Friar's balsam (tinct. benzoin comp.), to be reapplied from time to time, forms a protective film quite useful for wounds of the mucous membranes (as after operations in the mouth or anus) and for other moist surfaces, e. g., cracked nipples.

Bilateral inguinal herniae that pop in and out of the external rings, are very apt to be direct herniae. They often contain part of the bladder on one or both sides.

If possible, avoid giving an opiate for an abdominal pain until you know its cause. Morphine may mask the symptoms of an acute lesion, e. g., appendicitis, and delay the diagnosis.

Intratracheal anesthesia (Meltzer) is quite acceptable for operations other than intrathoracic. The etherization is almost automatic, danger of over-etherization is minimized, and coughing, straining and mucous accumulation are obviated.

When operating upon an incarcerated umbilical hernia, especially in an old or enfeebled subject, it may be quite desirable to enlarge the ring by incision before opening the sac. This will facilitate the reduction of the bowel promptly after its exposure.

When applying plaster-of-Paris immerse the bandages, on end, in a basin of water, deep enough to cover, one at a time as needed. As the bandage is lifted out, cover each end with the fingers to prevent loss of the plaster. Squeeze gently and pull off the raveled strands.

THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, JULY, 1913.

No. 7

MODERN METHODS IN THE DIAGNOSIS OF SYPHILIS.

DR. H. M. CONNER, Topeka, Kansas.

Read before the Kansas Medical Society, May 7, 1913.

Until the discovery of the *spirocheta pallida* by Schaudinn and Hoffman in 1905, the diagnosis of syphilis was based almost entirely on the clinical manifestations, and the treatment confined almost entirely to the use of mercury and the iodides.

Before this, there was one test that was used very infrequently that of Justus; depending on the increase of hemoglobin after the administration of mercury.

Since the discovery of the *spirocheta*, the advance in both diagnosis and treatment has been very rapid, in fact, the whole subject of syphilis has been almost entirely revolutionized. In 1905, Schaudinn and Hoffman found in the lesions of syphilis, especially the chancre and mucous patches, a spiral shaped organism, which, on account of its feeble staining power and the consequent pale appearance, they named the *spirocheta pallida*, afterward changing it to *treponema pallidum*. They found it in practically all syphilitic lesions and in none other than syphilitic conditions. Before the discovery of the *spirocheta*, other animals, notably apes and rabbits, had been inoculated with syphilis, using the virus from man. From these lesions in animals, the *spirocheta* was also obtained. Numerous attempts to cultivate it were made but no one succeeded in obtaining it in pure culture until 1911, when Noguchi announced that he had succeeded.

So now, it is absolutely proven that the *spirochete* is the cause of syphilis, as from these pure cultures the disease can be reproduced in animals.

Soon after the discovery of the *spirocheta pallida*, many methods of its demonstrations were brought forth. Those methods used chiefly today, are the dark field condenser or illuminator, the India ink method of Burri, the Giemsa stain and the silver impregnation methods.

Of all these methods the dark field condenser is the most serviceable and accurate, as in this method opportunity is had of observing their characteristic movements. In this method the spirochetes show as colorless spirals on a dark back-ground. They have a cork-screw motion and roll from side to side. Their length is from one and one-half to three times the diameter of a red blood cell. They are spiral in shape with the curls of the spiral, numbering six to twenty-six, very close together.

The India ink method of Burri seeks to replace the dark field condenser but is not so successful, because of the inability to watch the movements of the organism. In this method a drop of the serum squeezed from the previously curetted lesion, is mixed on a slide with a drop of Chin-Chin India ink and spread on the slide as in making a blood smear. This is then examined with an oil immersion objective. By this method the organisms appear as colorless spirals on a dark back-ground.

With the Griemsa method of staining, which is quite commonly used, the slides are stained as in staining for malarial organisms, except that the stain is allowed to act longer, and generally, one or two drops of a one-tenth per cent potassium carbonate solution are added to the distilled water used to make the staining mixture. The spirochetes show as purple organisms.

By the silver impregnation method of Stern the spirochete appears brown or black.

In obtaining the serum for any of the methods of demonstration of the spirochete, the parts should be washed with sterile water without antiseptic, and after thorough cleansing should be gently scraped with a curette or dull knife until the serum can be expressed. The presence of many red blood corpuscles is undesirable, as they obstruct the view of the spirochetes. If antiseptics, especially mercury, have been used on the lesion or if it has been cauterized, the search for spirochetes is rendered much more difficult and sometimes futile. Hence a positive result is of the most value. However, in untreated primary and secondary cases, they can almost always be demonstrated. Consequently the search for them is of the greatest diagnostic importance, especially in the early stages before the appearance of a positive Wassermann test.

For over a year after its discovery, the finding of the spirochete was the only method for the diagnosis of syphilis, from the laboratory standpoint. In 1906 Wassermann brought forth the test bearing his name, which is recognized the world over as the most reliable means for the recognition of syphilis, especially after the first few weeks.

Probably more literature has appeared on the subject of the Wassermann test than almost any other medical subject of modern times, with the possible exception of salvarsan.

It has been lauded and criticised and modified until its exact status is somewhat uncertain in the minds of a good many of the medical profession.

However, it has emerged from all the criticism with a greater name than ever, and is today recognized as one of the most accurate diagnostic methods, although not absolutely specific, and probably not due to the substances its author thought it was.

This reaction, according to the original idea of Wassermann is based on the observation of Bordet and Gengou that an antigen, (that is, a substance capable of producing antibodies when injected into animals), in the presence of the antibody produced by this antigen, takes up complement, so that when another set of antigen and antibody are added to the mixture, the complement is used up and the characteristic reaction does not occur. In the second set of antigen and antibody added to the mixture. This is on account of the fact that the complement has been bound by the first set of antigen and antibody, and is not free to act in the second set. The whole matter is based on the well-known side-chain theory of Ehrlich.

It is a well-known fact that blood serum exerts a certain destructive action on bacteria. This action is called bacteriolysis, and by suitable experiments can be shown to be due to two separate elements, the amboceptor or sensitizing substance and the complement or completing substance. In other words the amboceptor prepares the bacteria so that they may be destroyed by the complement. Either element is entirely inactive by itself, but each is necessary to the action of the other. The same action has been noted in connection with blood serum with which has been mixed the corpuscles of another animal. This destruction of red corpuscles is known as hemolysis and requires the action of both amboceptor and complement. The bacteriolytic bodies present in normal blood are called normal bacteriolysins, and the hemolytic bodies as normal hemolysins. By the injection of either bacteria or red blood corpuscles or various proteins into animals, antibodies specific for the substances injected are produced. These are called immune antibodies. On this phenomenon of immune antibody formation and the fixation or absorption of complement by the combination of antigen and antibody, was based the Wassermann test for syphilis.

But the conception of the reaction has changed, so that now

we consider that the binding substance in the blood of syphilitics is a lipotropic substance, (that is, a substance capable of uniting with a lipoid), rather than a specific antibody. The re-agents required are: The blood serum of the patient to be tested, the serum of a known syphilitic, the blood serum of a known normal individual, the blood serum of guinea-pigs, and the serum of a rabbit that has been injected with increasing doses of sheep corpuscles; also a suspension of sheep corpuscles and an extract of a fetal syphilitic liver or some other tissue of normal or syphilitic human beings or animals, depending on whose method is used. Nine-tenths of one per cent saline solution is used to dilute the re-agents.

The rabbit serum, the tissue extract and the guinea-pig serum must be standardized before being used, and the greatest care must be taken in the preparation of all the re-agents. On account of the large amount of work and on account of the apparatus required, the test will probably never be done very extensively by the general practitioner, but will be confined almost exclusively to the clinical laboratory. On account of the amount of time required, I will not attempt to describe the technique of the original Wassermann or any of its modifications.

As to the time of the first appearance of a positive Wassermann, authorities differ. Milne states that forty per cent of the cases have a positive when the initial sore appears. Quoting Lesser he states that one case was positive on the eighth day after exposure, fourteen days before the appearance of the primary lesion. Keidel reports one case positive as early as the fourth day after the appearance of the chancre. Craig reports one case as early as the fifth day after the appearance of the initial lesion. In my own work, the earliest positive I have ever seen was on the eighth day after the chancre appeared. In the majority of cases a positive will have appeared inside of three or four weeks after the beginning of the chancre. Some cases do not develop a positive until several weeks after the appearance of the secondary eruption.

As to the percentage of cases in whom there is manifest syphilis, giving a positive Wassermann, writers differ. The difference is due largely to the fact that the element of treatment has not been taken into consideration. Some of the discrepancy is due to the difference in technique and in the reagents employed. In primary syphilis the reports vary from fifty to ninety-eight per cent positives. Soon after the appearance of the chancre there will be very few positives while in the later days of the primary stage almost all will give a positive.

In secondary syphilis the results vary from seventy-nine to

one hundred per cent positives. However, in untreated secondary cases, a positive Wassermann will be obtained almost invariably. The lower figures are obtained on account of the inclusion in the statistics of treated cases.

In tertiary cases, the figures vary from fifty-seven to one hundred per cent positive. The variation here is caused by the inclusion of both treated and untreated cases in the statistics. Whether or not the case is healed or active also make considerable difference. The active tertiary cases give a very high percentage of positives. However, because a suspected case of tertiary syphilis gives a negative reaction, it can not be stated definitely that the case is not syphilis.

In latent syphilis the statistics also vary considerably. In early latent cases, or those late secondary cases without symptoms, from 20 to 80 per cent react positively. In late latent cases or those following the manifest tertiary stage, Noguchi reports practically the same figures from the literature. Hereditary syphilis gives positive results in practically all cases. Ulrich states that 95 per cent are active. In tabes the figures average about 60 to 70 per cent positives, varying from 40 to 80 per cent. In paresis, the figures run from 70 to 100 per cent, although most observers agree that a positive is obtained with few exceptions in both the blood and cerebro spinal fluid.

As regards the occurrence of the Wassermann reaction in non-syphilitic conditions, and in supposedly normal individuals, the reports of different writers vary.

Wassermann in 1910, is said to have made the statement that 10,000 tests had been performed in his laboratory without a single mistake. Schmidt, in a series of 1350 cases with 182 non-syphilitics, reports seven of these positive, six of which were lepers and one carcinoma. Boas reports over one thousand cases with one positive in a non-syphilitic. This was a case of scarlatina. It can thus be seen that reports of positive Wassermanns in non-syphilitics vary from none to four per cent. Barring leprosy, frambesia, and trypanosomiasis, none of which except frambesia is likely to be confused with syphilis, and none of which occur in this climate, a positive Wassermann is almost certain evidence of syphilis. It has been reported in a great variety of conditions, including malaria, carcinoma, diabetes and tuberculosis, but these cases are so few that it does not destroy the value of the test. The laws of Profeta and Colles have been almost upset by this reaction. Colles law states that an apparently healthy mother of a syphilitic child can not subsequently be infected by her child, thus imply-

ing that the mother is immune from syphilis. However, there have been a number of observations on this point and a large percentage of these women have been proven to be syphilitic. Conversely, the law of Profeta states that an apparently healthy child of a syphilitic mother cannot be later infected by its mother, again implying an immunity on the part of the child. In this case, also, there have been a number of tests made and a large number of these children have been shown to be syphilitic.

It can thus be seen that the Wassermann test is of the greatest importance in the diagnosis of syphilitic conditions. In the diagnosis of obscure cases, its value can hardly be overestimated. The etiology of many cases of habitual abortion can be determined by its use. Obscure nervous conditions are many times cleared up by the test, while bone lesions of unknown causation are frequently put in the list of those of known etiology. The distinction between brain tumors and gumma of the same organ can usually be made with the aid of the Wassermann test, although several writers have reported a positive test in connection with cases of brain tumor.

The value of the Wassermann in directing treatment has been recognized by our best clinicians, and is very widely used for that purpose, but it is not within the scope of my paper to discuss this phase of the reaction.

While the Wassermann test and the finding of the spirochetes are the principal methods for the laboratory diagnosis of syphilis, there are a number of other tests that are used to a certain extent.

These include Noguchi's luetin test, Noguchi's butyric acid test, Nonne's ammonium sulphate test, the test made with a pure culture of the spirocheta as antigen, the miostagmin reaction of Izar, the epiphanin reaction of Weichardt, and the cerebro-spinal cell count used in the diagnosis of tabes, paresis and cerebro-spinal syphilis. The luetin test is a cutaneous reaction analagous to the Von Pirquet reaction with tuberculin. For this test a killed pure culture of the spirocheta pallida is injected beneath the skin and in the course of 24 to 48 hours, usually there appears in the cases that are a positive characteristic reaction at the site of injection. This reaction is found in very few primary and untreated secondary cases, but Noguchi claims that it is of more use in the recognition of tertiary, hereditary and latent cases than is the Wassermann test. In tabes, and paresis according to his figures, the reaction was present in 60 per cent of the cases. The reaction is probably an anaphylactic phenomenon, and on this account does not appear till late in the disease, or until treatment has been administered.

Nonne's ammonium sulphate test and Noguchi's butyric acid test are both used considerably by some neurologists and psychiatrists. They both depend upon the increase in globulin in the cerebro-spinal fluid that occurs in syphilitic conditions, as well as in acute inflammatory conditions of the meninges.

Noguchi states that the butyric acid test will in many cases determine the existence of syphilis before the appearance of a positive Wassermann. Noguchi also applies his method to the blood. Notwithstanding the claims made for these tests, they have not yet come into general use, although some neurologists are very enthusiastic in their praise.

Noguchi has done considerable work with a fixation test, using a pure culture of the spirocheta as antigen. This is based on the same principle of complement fixation as the Wassermann test, except that the complement fixation in the spirocheta pallida reaction is caused supposedly by the antibodies specific for the spirocheta, while in the Wassermann fixation is caused by lipotropic substance formed in the blood of the syphilitic by the action of the spirochete.

Craig and Nichols have done a series of tests with cultures of the spirocheta pallida, spirocheta pertenuis and spirocheta microdent used as antigen, paralleling them with the Wassermann, and conclude that the test with the spirochete used as antigen is not of as great value as the Wassermann. However, so little work has been done on this phase of the fixation reaction, that it is too early to make any very definite statements as to its value.

The epiphanin reaction of Weichardt has not come into very extensive use on account of the very great complexity of the test. It is based upon the fact that when an antigen and its specific antibody are put in contact, the diffusion of the fluid is accelerated.

The miostagmin reaction of Izar has also failed to make much headway. Very little is written in the literature about this test, and so far as I can ascertain, there has not been any very extensive work done with it. It is based on the observation that when an antigen and its specific antibody are put in contact, there results a lowering in the surface tension of the fluid as is shown by the smaller size of the drops, measured by an instrument for the purpose.

Cyto-diagnosis or the count of the cells in the cerebro-spinal fluid is used very extensively by neurologists and psychiatrists in the diagnosis of tabes, paresis and cerebro-spinal syphilis. In these conditions the number of cells in the fluid is almost always increased, and in conjunction with the Wassermann test and the glob-

ulin precipitation tests of Noguchi and Nonne, and the clinical symptoms, the diagnosis can usually be made. Ball of Minneapolis, advocates the use of all four of these tests in all cases of obscure nervous disease.

CONCLUSIONS.

1. In early primary cases the examination for the spirocheta is of the greatest importance; next the Wassermann test. Both of these should be done whenever possible, as one tends to confirm the other.

2. In secondary cases the Wassermann is of more importance than the search for the spirochetes, although these may usually be found in the lesions of secondary cases.

3. In tertiary and latent cases the search for spirochetes is of much less value; while the Wassermann is of very great use. luetin test promises to be of some importance in this stage while of very little value in the primary and secondary case.

4. In latent lues the search for spirochetes is of little use, while the Wassermann is found positive in over half of the cases. The luetin test also promises to be of value here.

5. In parasyphilitic conditions, the search for the spirochetes is futile, while the Wassermann test is of the greatest value, especially in the diagnosis of paresis in which it is found in nearly all cases. In these conditions, paresis and tabes; the cerebro-spinal cell count is also of great value while the precipitation tests of Nonne and Noguchi are said to be of considerable worth.

6. In hereditary syphilis the search for spirochetes is very seldom used, while the Wassermann reaction is of the utmost value. The luetin test also, according to many observers, is of a good deal of importance here.

7. The complement fixation test with a pure culture of the spirochete as antigen has not met with great favor so far, although theoretically correct. It does not seem to be of as much value as the Wassermann test. More work will have to be done with this reaction before its exact status can be decided.

8. The epiphanin and miostagmin reactions are not used enough to allow of any very definite conclusions as to their value.

9. Up to the present time the Wassermann test and the examination for the spirochetes with the promised addition of the luetin test, constitute the principal laboratory methods for the diagnosis of luetic conditions.

OBSTRUCTION OF THE UPPER AIR PASSAGES.

DR. J. R. SCOTT, Newton, Kansas.

Read before the Kansas Medical Society, May 7, 1913.

The regions included in this discussion are the nasal chambers, the epipharynx and the collateral cavities which open into them, namely, the frontal ethmoid and sphenoid sinuses, the maxillary cavities and the mastoid antra and cells. All of these collateral sinuses are liable to infectious and inflammatory processes due to pathological conditions within the main air passages. To treat this topic intelligently we must constantly keep in mind in our discussion the physiology and functions of the organs involved. For not only is the nose the organ of smell, but upon the proper use of the upper air passages depend the processes of respiration, vocalization and the receiving and transmitting of sound waves. It necessarily follows that a pathological condition anywhere in this region will interfere with normal functioning. It is well understood that mouth breathing is detrimental to both mental and physical development, so we may easily conclude that this in adult life results in imperfect physical and mental processes. It is well recognized that mental sluggishness in children is due not only to faulty breathing but to actual circulatory changes within the cranium, so it is quite possible that the change within the region at the base of the brain, especially in neglected cases, may be permanent and result in lowered brain functioning. It is a fact capable of ocular demonstration that neglected cases of mouth breathing are indelibly marked physically so it seems not unreasonable to assume that the damage done to the mental functions is also permanent. If this be so, it adds an additional reason for persistently teaching the necessity of early establishment of nasal respiration.

The most frequent cause of obstructed breathing in children is adenoids. Adenoids not only block the posterior nasal openings but retard the natural growth of certain of the facial bones and the capacity of the nostrils is both relatively and actually lessened. The palatine arch is narrowed laterally, thus decreasing the width of the nostrils and the central part is pushed upward elevating the floor of the nose. This causes the vomer and triangular cartilages and sometimes the perpendicular plate of the ethmoid to buckle, causing further obstruction in the already too constricted nasal chambers. Adenoids are the result of overgrowth of lymphoid tissue in the epipharynx. Undoubtedly part of the growth is

due to proliferation of lymphoid cells and part is probably due to circulatory changes. At any rate changes in the size of the mass take place rapidly so that one may breathe fairly well in an erect position and find the choanae blocked in a recumbent position. This increases the congestion in the surrounding tissues, the tonsils are apt to enlarge, pressure is made on the eustachian openings, the secretions become more abundant, the tissues lose vitality; pathological bacteria multiply and a more or less virulent inflammation in the pharyngeal portion of the tubes is started, which either by contiguity of tissue or by the retention of septic secretion, is extended to the middle ear. Thus a foundation is laid for chronic disease of the middle ear or mastoiditis. Either trouble, if unchecked, will result in deafness. Middle ear disease is so closely connected with disease in the pharynx that bilateral purulent otitis media in a child is sufficient evidence to warrant a diagnosis of adenoids. Middle ear disease is largely a disease of civilization. The "untutored savage" who unloads his nostrils by placing a finger against one and blowing free through the other is less liable to tubal infection than his civilized relative who compresses both nostrils and inflates the eustachian tubes in his efforts to bury the discharges in a handkerchief.

While the vocal chords are the principal organs of speech, the nasal chambers and collateral cavities have much to do with tone production. The sound waves set in motion by the vocal chords are thrown upward against the vault of the pharynx, and reflected forward into the air chambers in front of it, and it is the unimpeded movement of the sound waves within these cavities that gives to the voice its proper quality and resonance. Therefore, anything that impedes sound vibration or reflexion, interferes with voice production. But in a more direct way, nasal obstruction impairs voice production. Adenoids in the vault or contact surfaces within the nasal chambers cause irritation, this augments secretion, and this in turn following the pharyngeal walls, cause the irritation to extend to the larynx. There results thickening about the laryngeal muscles, the easy movements of the cartilages are lessened and the flexibility of the voice impaired. Even trophic changes occur in the chords themselves and the power of sustained tones through unusual periods of speaking or singing is lost.

In the adult obstructions to normal breathing are usually within the nasal cavities. It is rare that adenoids large enough to obstruct breathing persist past maturity, although in many cases their persistence causes trouble in other ways.

In tone production we spoke of the necessity for free vibration of sound in the nasal chambers, so in respiration the passage of air through them must be unimpeded. It is not enough that the air pass through the nostrils, but it must pass through in a physiological manner. The inspiratory function of the nose is to temper the air and humidify it, as well as strain out particles of solid matter, that the air may reach the lung in the best possible condition. By far the most important structures in the nose for this function are the turbinate bodies. They are shaped to deflect the air current against the warm moist membranes without obstructing it. The middle and inferior turbinates incompletely divide the nasal chambers into three cavities. Near the roof of the superior meatus are the openings of the posterior ethmoid cells and posterior to this is the sphenoid opening, while at the anterior part of the middle meatus is the opening of the anterior ethmoid group and the frontal sinus, while posteriorly lies the opening into the maxillary antrum. These cells are lined by secreting membranes and furnish moisture that should be taken up by the inspiratory current. Therefore in physiological breathing the inspired air should pass from the nostril high into the roof of the nose, abstracting the moisture from these cells, thus reaching the lungs humified. The return current, already laden with moisture, should pass outward near the floor of the nose which is comparatively dry. The higher course of the inspired air and the lower one for expired air are absolutely essential to physiological breathing. Very often individuals who have abundant air space in the nostrils suffer because of the pathological conditions within the nose. With them physiological breathing is impossible, and their ills are almost, if not quite as great as that of the mouth breather. The higher levels of the nostrils are obstructed, the proper ventilation of the nasal chambers is imperfect, secretion is too abundant, and a feeling of fullness and an anterior or posterior discharge, causes discomfort. This condition long continued, brings about trophic changes and results in permanent damage to the nasal structures and deranged functioning.

Polypi are the result of excessive moisture in the roof of the nose and of the air cells that open into it. The membrane surrounding the mouth of the cells or within them becomes degenerated and the result is the growth of these tumors. Often the membranes of the middle turbinate degenerates and the tumors spring from it, or the anterior tip of the turbinate may take on the appearance of a polyp. These conditions result from improper ventilation of the nose and are usually associated with ethmoiditis.

On examination adenoids often may be seen through the nostril even in young children. Instruments are now made which illuminate the vault so that the growth may be seen through the buccal cavity. Facial expression, middle ear disease, discharge from the nostrils, mouth breathing, and in older children, lack of physical and mental vigor, point strongly towards adenoids. Inability in a child to concentrate the mind is presumptive evidence not to be overlooked. As a last resort, the adenoids may be felt with the finger introduced into the vault through the mouth, although this is seldom necessary.

Middle ear disease may be discovered by inspection of the drum. The patient may complain of pain or deafness. Pain along the course of the eustachian tubes indicates tubal catarrh and usually indicates middle ear disease. Increased or diminished quantity of cerumen in the external canal is evidence of middle ear disease; the former of more recent, the latter of long-standing involvement. Mastoid infection is usually accompanied by pain but this cannot always be depended upon as a symptom. Discharge from the ear of more than a few weeks duration is also symptomatic of mastoid disease. Transillumination will aid in clearing up uncertainties in some cases.

The sense of smell is usually obtunded in ethmoiditis and disease of the frontal sinus. The patient also complains of dizziness, often also of pain and fullness between the eyes. Inspection reveals the presence of discharge, which, if in the superior meatus, indicates disease of the posterior ethmoid cells or sphenoid cavity, and if in the middle meatus antrum, ethmoid, frontal or maxillary cavities are involved. Transillumination and the X-Ray are useful aids. After suction a discharge may be apparent when before its use, none was evident. There are cases that will require the most careful examination and exhaust the resources to arrive at a correct conclusion, so vague and uncertain are all the symptoms.

Septal deformities and diseased turbinates can be detected usually by inspection with a good light. Post nasal discharge, with adenoids excluded, usually indicate pathological conditions in the nostrils. Polypi are readily recognized by their color, but must not be confused with thick viscid secretion. This has occurred.

Adenoids should be removed as soon as a diagnosis is made. This is an operation not difficult, but often poorly performed because of faulty position of the patient, badly designed instruments and poor technique. The patient's head should be thrown forward, the chin directly over the supra sternal notch. Instruments

modelled after Gottstein are poorly designed and with them the best work is impossible. Adenoids will rarely return if entirely removed.

After the adenoids are removed, if children under twelve, still have insufficient air space, particularly if the palatal arch is high and nasal septum is deflected, they should be referred to a dentist skilled in orthodontia. By widening the dental arch he will lower the hard palate and increase the internasal space a sixteenth of an inch or even more, and in so doing he will give sufficient breathing space and reduce the deflexion in the nasal septum. It is seldom necessary to do intra-nasal operation before puberty. The removal of adenoids and proper placement of the hard palate will accomplish all that a nasal operation can; and in a more normal way. After puberty it is not certain what the dentist can do in neglected cases, and the nasal surgeon can then best correct obstructions by work within the nose. Let it be understood that all obstructions that persist until puberty are neglected. The obstructions should be removed prior to maturity. Bearing in mind the importance of the turbinate bodies, when it is possible to correct the defect by work on the septum, this should be done. And of all methods of correcting septal deformities, the submucous resection is by far the best. This method lends itself as readily to the removal of a spur as to the most complicated deviations, and the results are more permanent and satisfactory.

Removal of the lower turbinate is wrong in principle and unfortunate for the patient. A boggy lower turbinate nearly always responds to treatment higher up in the nose and as true hypertrophy is comparatively rare, the cautery has but a limited use in nasal treatment. Diseased middle turbinates may be removed in part, or entirely and when the free passage of air or the drainage of the cells in the roof of the nose is blocked, enough must be done to re-establish drainage and ventilation. The use of the cautery here is only mentioned to be condemned. It is dangerous, and there are better and more certain means of securing the desired results.

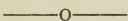
It will take too much time to discuss treatment of the collateral sinuses and particularly of the ethmoid cells, yet this question will intrude itself into this discussion. It must be remembered that the distribution of the olfactory nerve is largely to the upper part of the middle turbinate, and not at all to the ethmoid cells; so the turbinate should not be needlessly sacrificed. The surgeon should be sure that no better remedy exists before performing an operation that will interfere with the olfactory sense, because to

obtund this function also lessens the more delicate gustatory sensations. It is, or ought to be, the aim of the nasal surgeon to preserve function not destroy it, and to needlessly injure olfactory and gustatory sensations is not good surgery. In selected cases proper attention to the ethmoid cells will re-establish drainage and ventilation, without sacrificing any essential part of the middle turbinate. The integrity of which should be preserved when it is possible to do so. If one will keep in mind the physiology of respiration and the necessity of drainage in the upper nose and do enough to secure these and prevent contact surfaces between the septum and lower turbinate, he will have established the thing desired, physiological respiration.

In the middle ear disease, prevention is of the highest importance. This can be more surely accomplished by making and maintaining healthy conditions of nose and throat, for out of a diseased nose and throat come all middle ear diseases and the subsequent deafness. It is folly to try to cure diseased ears without removing the cause. In the chronic form, if the nose and throat are put in a healthy condition, the inflammation usually subsides. In the acute form drainage is essential and if the eustachian tube is not patent, the drum must be incised. To wait until there is a decided bulging of the drum is to allow the patient to suffer and subject him to unnecessary danger. The antrum wall has less resistance than other parts of the middle ear and is diseased early where pus is retained. The incision must be done under aseptic precautions as must also subsequent dressings. A gauze drain inserted in the external canal in such a manner that it will come in contact with the opening in the drum will aid greatly in freeing the middle ear of pus. In tubal catarrh with a perforation, a solution of iodine, alcohol and glycerine is useful. This is also a valuable solution used early in acute cases, if warmed and dropped into the external canal. In cases where the discharge continues beyond a month or six weeks the antrum should be opened and a mastoid operation done after the method of Mr. Chas. Heath of London. This obliterates the mastoid cells and antrum, and eradicates the disease; preserves the hearing present and often restores it completely, while if the disease is allowed to run on or be mistreated by treatment the result finally is deafness.

I have said little about medical treatment in these cases, because nasal obstructions and middle ear disease in prevention and cure are surgical diseases. It is easy to cut away tissue but impossible to restore that which is lost, so one should be conservative. Effective thoroughness is however, more conservative than in-

effective expectancy. Nasal surgery is more than "making a hole" through the nose; it is establishing normal conditions within this organ. Because poor nasal surgery does not result fatally, gives a physician no license to commit mayhem on his patient. But careful, conservative, intelligent surgery on this organ will be a great comfort to the patient and a source of satisfaction to his physician. The sooner the medical profession realize this and throw away sprays, douches and ear massuers, and begin a rational treatment of causes, the sooner will deafness and other diseases of the collateral sinuses of the upper air passages become infrequent, and the special senses of hearing, taste and smell be preserved to the largest possible extent.



THE PRESENT APPROVED METHODS OF TREATMENT OF OBSTRUCTIONS TO THE LACRIMO-NASAL DUCT.

E. N. ROBERTSON, M. D., Concordia, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

If I mistake not the subject of lacrimo-nasal disease has not been discussed by this society during the past several years and in casting about for a theme to write upon, it occurred to me that the above mentioned one might not prove altogether uninteresting.

The diversity of methods used in the treatment of affections of the lacrimo-nasal apparatus is sometimes confusing. Good authorities have in times past differed, one recommending one form of treatment, another condemning it; and it is usually not until one has had some experience in treating these cases that he appreciates the value of one method over that of another. At the present time, however, judging from the current literature and reports from ophthalmological societies, certain forms of treatment in these conditions are being quite generally agreed upon. The state of the disease, acute, subacute, chronic, and the state of the patient as regards his ability to have one measure carried out in preference to another, determines the method to be pursued. For instance, probing in a given case might offer hope of good results, yet the patient being unable to come at regular intervals to have it carried out, or being too nervous to endure such sittings; extirpation of the lachrymal sac would probably be indicated.

Owing to the broad scope of this paper some details of the treatment and technique must of necessity be omitted. To describe each step minutely would not be possible in the time allotted.

In the first place, there are cases of obstruction in the lacrimo-

nasal passage which, in the beginning can be relieved by very simple measures, but which if allowed to go on would often result in chronic obstruction with dacryocystitis. The simplest of these cases I have found in infants and children. One is presented, for instance, with epiphora of short duration. On inspection the nose will usually be found stenosed, and if the tumefaction on the affected side is not sufficient to block the opening from the nasal duct into the nose, the swelling has probably extended up to involve the submucous tissues of the duct itself, causing the obstruction to the outflow of the tears. Simple astringent remedies applied to the nasal mucosa with a solution of argyrol for the conjunctival sac for a few days is usually all that is necessary to effect a cure.

The next variety of cases is that in which the epiphora has been present for some time, perhaps untreated; or where the more simple measures have failed to give relief. In these cases, as well as those to be described later; it is my custom, as a routine, to dilate the punctum and canaliculus slightly and syringe a few c. c. of boric acid solution into the lachrymal sac. If the upper canaliculus is patent the fluid will return through it to the conjunctival sac; and if the nasal duct is not entirely closed a few drops of the solution will enter the nasal chamber. Whether or not it is possible to get any fluid into the nose at the first sitting, repeated trials on subsequent days, by inserting the blunt point of the lachrymal syringe through the canaliculus into the upper end of the nasal duct and gently forcing an astringent antiseptic solution into the duct will frequently open the passage, and along with appropriate nasal treatment, bring about a cure. It is needless to add that the above measures are painful unless sufficient cocaine is instilled to anesthetize the parts.

The next variety of case is one in which a chronic state has supervened, with not only constant epiphora, but with a varying degree of mucopurulent discharge from the lachrymal sac. While exceptionally, syringing with suitable antiseptics, as described in the preceding paragraph, if persisted in long enough, will bring about happy results; it is the rule that more radical measures must be adopted to relieve the condition. This is because a well defined stricture has formed in the majority of such cases, and unless it is cut through and the parts kept open until it heals, or the lachrymal sac removed, little hope can be offered for recovery from the dacryocystitis. This class of cases with varying degrees of pus formation, acute and chronic, is the most numerous with which the physician has to deal, and to the treatment of which the major portion of this paper is devoted.

Let us now consider the best method of handling an acute dacryocystitis, complicating a more or less complete obstruction of the nasal duct. Acute dacryocystitis is rarely a primary condition; lacrimo-nasal disease of some kind preceding practically every case. We are instructed in one of our standard text books on ophthalmology to wait until pus has formed and then incise the lachrymal sac from the outside; and this method has in times past been an approved one. However, a fistula commonly results, requiring much subsequent treatment, with the frequent necessity of extirpating the sac finally. Two other methods are now quite generally preferred by ophthalmic surgeons. The first consists in slitting the canaliculus, preferably the lower; and forcing out the pus by pressing on the swelling from below upward. General anesthesia is usually necessary, and, if desired, the duct can be probed at the same time. This method is advocated by several prominent eye men; Posey, of Philadelphia, being one. The results, however, are not always as satisfactory as those obtained by the next procedure to be described.

The method par excellence, and, I believe, destined to be universally adopted by ophthalmologists, is one which was advocated by Agnew about forty years ago, and lately revived by Vierhoeff of Boston. General anesthesia is required unless the patient has an unlimited tolerance to pain. Cocaine or other local anesthetics do not help any in such cases. This method, essentially as given by Agnew and Vierhoeff, consists in an incision into the sac starting at a point between the caruncle and the inner commissure of the eye lids; the cavity of the sac can thus be easily reached. is emptied of its contents without difficulty and no external wound is left to embarrass one in the after treatment. The incision is best made with an angular knife or keratome. It is plunged through the sac to the lachrymal bone. Hemorrhage is free at first and pus does not always come until the incision is widened. The nasal duct should always be probed to break through the stricture and widen the passage into the nose, rapidly working up to the largest size probe, which is then left in the duct until the patient begins to regain consciousness. According to the method of Ziegler of rapidly dilating the passage in most all forms of lacrimo-nasal disease, subsequent probing would seem unnecessary, but it is safer to use the probe for a few times on alternate days. This is done through the original incision.

Not so very many years ago probing the nasal duct with one of the various forms of probes was the approved treatment in most forms of lacrimo-nasal obstruction. At the present I dare say com-

paratively few surgeons use the probe as a routine. The most favorable cases for the use of the probe are those in which the contraction is caused by simple inflammatory swelling of the mucous membrane, and, as previously shown, many of these cases can be relieved by syringing judiciously carried out; those cases in which cicatricial strictures are present are less favorable, and the least favorable are those in which the nasal duct is obliterated at one or more points. In the last instance the sac must generally be removed or obliterated.

Ziegler of Philadelphia, was one of the first to give up the constant probing of these cases, and substitute for it his method of rapid dilatation. In this procedure the canaliculus is not even slit; his cylindrical needle probe is introduced into the punctum and gently forced through the canaliculus in a horizontal direction until the bony wall of the lachrymal sac is reached. It is then withdrawn and his larger oval pointed cylindrical dilator is introduced and follows the course of the needle probe until the lachrymal bone is reached. The point of the dilator is then held firmly against the bony wall while the shaft is raised 90 degrees to the vertical position. Hugging the bone the point of the dilator is then made to slip downward until it engages in the opening of the bony canal; it is then forced with firmness downward and slightly forward through the stenosed duct into the nose. In those cases ordinarily favorable to probing good results are obtained without subsequent treatment; in the more obstinate cases supplementary measures such as styles and irrigation are almost always necessary. One thing which especially commends this method is that by it the normal capillarity of the canaliculus is retained.

In regard to styles, there are several kinds in use, the most generally approved being those made of an alloy of lead and zinc or lead and tin. The lead style has been more or less popular in the treatment of obstructions of the nasal duct ever since it was first recommended by Green in 1868. Personally some of my unique results in chronic dacryocystitis have been obtained with the lead style. In cases showing great tendency to closure of the duct, where the patient will not submit to an extirpation of the sac, the style will frequently bring about a cure, if left in long enough and properly attended to. I use the ordinary fuse wire obtained of the local electric light company, from $1\frac{1}{4}$ to 2mm. in thickness. It is not necessary to make a groove on the wire for the conduction of the tears, although some authorities recommend it. The style should be made long enough to permit its smooth rounded end to rest on the floor of the nasal cavity and the top

should be hooked or bent so as to allow it to fit nicely into the groove made by slitting the lower canaliculus. To introduce the style the canaliculus is slit with a Weber's knife or some other suitable instrument, a passage is forced through the stricture; if one is present, with a probe, or the stricture is cut with a stricture-tome, and the duct is dilated with a probe slightly larger than the style to be used. The easiest way to insert the style is to use the lead style introducer devised by Ziegler. It has a double groove to fit the vertical and horizontal portions of the style. The fingers or any small grasping forceps may be used, but care should be taken not to roughen any portion of the style, which would cause it to irritate the passage. The introducer obviates any trouble of this kind and greatly facilitates the placing of the style. As to the length of time it may be worn, I had one patient who wore the fuse wire style with perfect comfort for three years. It was finally removed and two years have elapsed with no recurrence of her dacryocystitis, which was originally an obstinate case. Instances are on record of cases wearing the style for much longer periods than this.

After introducing the style it is my custom to allow it to remain for about a week if the drainage keeps good. It is then removed and the lacrimo-nasal passage syringed with a saturated solution of boric acid. If the duct is then large enough to permit of the easy introduction of the style again, it is replaced at once; if it goes in with difficulty. I gently probe again which makes the second introduction of the style easy. As a rule after the first two or three times the style goes in without difficulty. The intervals between the removal of the style are gradually lengthened, if all goes well, until a month or six weeks goes by a couple of times without changing. Soon after this in the majority of cases it is safe to remove the style and leave it out, a cure being thus accomplished in from twelve to sixteen weeks.

The best results as regards relief from epiphora are always obtained by some form of probing or by the use of the style; but cases are met with where nothing but removal of the lachrymal sac will afford relief from the recurring attacks of dacryocystitis. In such cases there is usually either a bony stricture or some bony necrosis of the nasal duct. By far the large majority of cases presented for treatment can be relieved by the less radical measures if competence on the part of the surgeon is combined with patience and persistence.

I wish at this point to report a case, not for the purpose of refuting previous claims, but because it is interesting and somewhat

unusual, and also to illustrate the fact that after all is said, each case is frequently a law unto itself. Mr. B. a lumber dealer, came to me in the spring of 1908, suffering from a chronic dacryocystitis of about twenty years duration. It was his habit to press pus from his right lachrymal sac once or twice a day for many years. He had consulted a number of physicians and tried many local remedies without avail during this time. Having heard of the possibility of a cure by probing he came to me for this purpose. I told him frankly that I could offer him little hope of a cure by probing; that in his particular case extirpation of the sac was probably the only thing which offered a reasonable chance for recovery. But he insisted that I try the probing and so I did. The canaliculus was slit, the sac washed of its foul contents, the stricture in the nasal duct cut through and the probe passed. There was some irregularity in the bony canal and I felt the task was more hopeless than ever. After I had treated the patient for ten days with probes and irrigations, he disappeared. He returned again in about a month stating that he thought he was about cured when he left and quit for a while to see what the result would be. I found his condition nearly as bad as at first when he returned and I reopened the lacrimo-nasal passage. He stayed with me only a short time again and I next learned that he had gone to Kansas City, to be treated by a specialist there. In about eight weeks he returned to me again and said he would stay with me six months, if necessary, if I would only try to cure him by probing. I argued with him again as to the foolishness of wasting time having a condition treated which probably would not get well without an operation. But he was obdurate and we started in again. After getting the sac clean and reestablishing the passage by probes, I inserted a lead style. In three days I had to remove it, as it blocked the drainage. I next probed and irrigated for a few days and then inserted a silver canula. This gave more trouble than the style and had to be removed. The probing was then recommenced and kept up daily with irrigations for twelve weeks. At this time a number of 16 Theobald's probes could be introduced with ease. I then began to lengthen the intervals between the probings and finally at the end of three months from the time we began the last course of treatment I discharged the patient. I gave him, however, a number 12 probe with instructions to pass the same every few days for a couple of months. This patient was so grateful for the relief of his trouble that he wrote me about every six months for three years telling me that his "game optic was still all right."

TO SUM UP:

1. The majority of all cases of lacrimo-nasal obstruction, in the beginning, can be relieved by very simple measures.
2. Syringing with mild astringent antiseptic solutions should always be tried faithfully, even in those cases where a mucopurulent discharge from the sac is present.
3. It is better as a rule not to open an acute dacryocystitis through the skin. More satisfactory final results are obtained by letting the pus out through the canaliculus, or by the incision of Agnew; followed by the use of the probe.
4. Rapid dilatation by the method of Ziegler is sufficient to effect a cure in many cases formerly made tedious by probing.
5. The use of the style in suitable cases is much preferable to probing.
6. Good results can be accomplished by probing in selected cases if the patient will stand for it.
7. When quick relief to chronic dacryocystitis is desired, extirpate the lachrymal sac.

—o—

THE IMPORTANCE OF INSPECTION AND STANDARDS FOR MEDICINAL SUBSTANCES.

PROF. L. E. SAYRE, University of Kansas, Lawrence.

Read before the Kansas Medical Society, May 8, 1913.

It has been with no little timidity that the writer has accepted the complimentary invitation of your Secretary to present a paper on "Standardization", partly because there is apparently existing differences of opinion concerning certain phases of the subject as viewed from the standpoint of the physician and from that of the pharmacist.

Standardization of medicinal agents touches acutely the interests of the pharmacist and the physician. Neither can afford to neglect the opportunities offered by it to his respective calling. Both professions may profit by the proper enforcement and by the broad application of the principles involved in the law relating to it.

It has frequently been stated that unless all the sources of supply of remedial agents (clear to the consumer) be guarded, our Food and Drugs Law becomes more or less ineffective. If there are any avenues left open for the exploitation of sub-standard material there are those found ever ready to enter them and to supply this material at all prices and in any quantity. It is unnecessary to repeat that the reputable houses are too upright and honorable

to stoop to the practice of even carelessly standardizing their products or that they would yield to the temptation of supplying two grades—one grade for localities subject to inspection and the other for other localities which are not frequented by inspectors. It is also needless to repeat that reputable physicians in every possible way at their command secure for themselves remedial agents which would creditably pass the inspectors and would meet the requirements of the standards. Nevertheless, the theory is tenable—a loop-hole, however small, for the introduction of sub-standard material furnishes an incentive for an evasion of the law—such incentive will invite those, always ready; to take advantage of it. Experience has shown this to be true.

It has been stated, and I believe not without foundations, that there are some corners of the state of Kansas which furnish good fields for the exploitation of inferior preparations. Other states, which have poor administration of the law applying to medicine, complain bitterly of the existing conditions, which illustrates the force of the remark that there are those ready to furnish medicine without reference to quality.

In the last Kansas legislature, there was an act passed which had for its object a broader application of the Food and Drugs Law as applied to the sale of and to the dispensing of medicine. This act, amendatory to the old Pharmacy Law, after reciting numerous restrictions imposed upon the pharmacist as a dispenser of drugs, states in Section 5:

"Nothing hereinbefore contained in this act shall prohibit any practitioner of medicine from administering or supplying to his patients such articles as may be fit, proper and necessary, provided drugs and medicines dispensed by him shall comply with the Kansas Food and Drugs Law and be subject to inspection as provided in said Law."

This act also provides that every one who dispenses from a stock of drugs shall be responsible for the quality of all drugs, chemicals and medicines he may sell or dispense.

Unfortunately, there is no provision in the law for the expense of such broad inspection of drugs and medicines except as funds may come to the Board of Pharmacy through its channels of registration or as may come to it by contribution. There is no provision by which expenses of such examination shall be assumed by the Board of Health. Therefore, in order to make this law of beneficial effect, it is in the hands of the physicians themselves to encourage and foster its execution for their own protection and welfare. When the bill was presented to the legislature, it was

gratifying to state that it received the opposition of only those physicians who did not understand the purport of the bill itself. Unfortunately, very little or no missionary work had been done among physicians to promote it because of the lack of funds to accomplish this. However, some missionary work was done individually. Physicians and medical societies were consulted. For this service I am indebted largely to Dr. Sippy of Belle Plains, Kansas, who has made the statement that he never interviewed a single physician who, after the proper explanation, did not agree that the proposed law was thoroughly equitable in every respect and that it possessed much merit. He further stated that the only ones in the medical profession who raised an objection were those who had no comprehension of its good features.

We have had opportunities of obtaining the sentiment and attitude of some who have been more or less seriously affected by the law and we have been extremely gratified to learn of their enthusiastic support of it. Furthermore, physicians are just beginning to learn that the broad application of the principles of standardization is beneficial in many directions. Physicians are voluntarily sending to the laboratory samples of suspected material upon which they are asking for reports. Some of these examinations show adulteration—others have shown that suspicions were unfounded—that the medicinal agents suspected were true to standard.

Standardization as applied to medicine had its beginning in this country as early as about 1854, when our importations of drugs at the port of New York were first inspected. Since that time, through the influence of both professions, pharmacy and medicine, the application of its general principles have developed a system which is so fostered and popularized as to have a powerful controlling influence, amounting, through public sentiment, almost to compulsion in a very favorable direction. The first application of standardization was in the direction of the determination by qualitative and quantitative analysis of the amount of possible impurities in inorganic medicinal chemicals due to added adulterants, to an imperfect process which failed to remove natural adhering impurities, or to natural deterioration. Very clear, concise and accurate processes of analysis have been devised for the detection of these impurities and adulterations.

During the days of the Empirics the properties of medicinal agents were so vaguely interwoven with superstition that the conception of definite proportion was almost inconceivable. Medical practice has not yet entirely divorced itself from superstition but

it has reached a stage where drug therapy is based upon quality of material and upon definite and accurate proportion of the active medicinal agent or constituent. Belladonna, for example, is active in proportion to the atropine and other alkaloidal constituents; opium in proportion to the morphine constituent; nux vomica in proportion to strychnine constituent, etc. Hence, there is a definite relation between disease and remedial agent of which the Empirics never dreamed. Pharmacology has made this relation still more emphatic. Facts resulting from pharmacological study have shown, for example, that the relation of curine, obtained from curare, on methylation, yields a derivative which is 226 times as poisonous as the original substance—that morphine by dehydration produces a systemic emetic of less poisonous character than the narcotic morphine. Pharmacology also lends its contribution to the chemist when his skill is baffled in testing, by chemical means, the physiological activity or toxicity of a given agent, as in the case of ergot, cannabis indica, digitalis, strophanthus, etc.

The effects of the cooperation of pharmacology and chemistry have been manifested recently in the standardization of remedial agents as such. The Council on Pharmacy and Chemistry of the American Medical Association in its last issue makes the following significant statement:

"It is generally recognized by physicians who have given attention to the matter, that a considerable proportion of the articles in the Pharmacopoeia of the United States and in the National Formulary are worthless, irrational, obsolete and superfluous. Repeated efforts have been made to have at least the more objectionable of these articles eliminated. These efforts, however, have uniformly encountered the objection that the articles or preparations are used by some physicians and should therefore be recognized and authoritatively defined."

This process of elimination, having once started on a thoroughly scientific basis, it is almost impossible to predict what its final result will be. Unquestionably there will be an arraignment of many of the popular remedial agents—popular in the sense of their being commonly prescribed by physicians. This process of elimination, if we may be permitted to predict, will extend beyond what is known as the official and semi-official preparations into the domain of nostrums and patent medicines.

In reference to this subject of nostrums and quack remedies, it may be stated that the reign of quacks has not ended with the 20th century. The scepter is held with a firmer grasp and the Empire has even a wider range. It is said that from 1880 to 1912

the number of proprietaries increased from 4,194 to 38,813 and this increase was largely from 1900 to 1910. The production in 1904 was \$117,000,000 and in 1909, \$142,000,000. In 1911, it was \$160,000,000, and this exclusive of proprietaries made by cooperative companies. This record is taken from the Canadian Pharmaceutical Journal, November, 1912, from a report of the National Wholesale Druggists, Association of the United States, held in October last, in Milwaukee. We do not propose to place the responsibility of this accumulation of good, bad and indifferent remedial agents upon any class of persons, professional or unprofessional. It is, however, in our opinion, true that we are all to a greater or less extent slaves of quackery in one shape or another. But the responsibility of checking fakes and frauds rests with the two professions, pharmacy and medicine. These two professions are now provided with the tools and the administrative machinery for curbing, at least, this mischief and damage to the public welfare. The broad application of the principles of standardization is all that is necessary to accomplish this. It is very unfortunate that very little progress has been made in the direction of standardizing what is known as patent medicines. Pharmacists are accused, and we think unduly if not unfairly, of the exclusive exploitation of this class of agents. Relative to this perplexing and exceedingly annoying question we wish to quote the introductory paragraphs of an article which was published in the August number of the Journal of the American Pharmaceutical Association, which read as follows:

"Like the gallant soldier who said in his letter, 'I am writing this with my sword in one hand and my pistol in the other.' so the modern pharmacist stands before the medical profession, with one hand full of proprietary cure-alls and with the other distributing literature advocating a return to rational prescribing and an increased use of official preparations."

"Without attempting to excuse him altogether, the writer feels that the charge so frequently made that the druggist is attempting to work both ends from the middle is in a large measure unjust. Those who make it do not realize that the druggists' apparent inconsistency is pressed upon him by force of circumstances in which patent medicines represent his business necessities, while the propaganda for rational prescribing represents his aspirations for better things and his strivings for a more professional as well as a more profitable business."

We are sure of what we say, when we assert that the average pharmacist has an ambition for higher pharmacy and that he is

striving against odds on the one hand to make an honest living and on the other to endeavor to elevate the tone of his profession. He craves the opportunity of using the skill and knowledge required of him by law and to him the tendency on the part of those in his vocation to introduce foreign sidelines is distasteful. We know that he has a decided anxiety to improve the character of his vocation, his methods of compounding and to add to his usefulness to the physician. The public as well as the medical profession should be concerned, and to guard it as well as the sister profession against unbridled commercialism, it seems to us, in the up-building of this vocation. Theoretically, the practice of pharmacy, as well as the practice of medicine, is restricted by law to persons properly qualified. This is considered essential to the welfare of the community. The obligations which pharmacy takes upon itself as a custodian of medicines includes its donations to the science of the results of its investigations, as well as the observance of certain ethical rules. Carried to its logical conclusions it would seem that the public, in granting a license to pharmacists, pledges itself to protect the calling and expects as a return a certain service which is partly concluded in the building up of the profession itself and in the efforts which it may put forth to guard the public against fraud.

We are not here to defend any of the many reprehensible practices of either one or the other professions and certainly not as one loyal to pharmacy to go out of our way to bring to light those things which are obnoxious and vicious. We would prefer to point out a way in which representative physicians and pharmacists might on the higher planes, cooperate in circumscribing at least, the limits of the faker and nostrum maker, if he must be considered as a necessary evil—an obligation entrusted to these professions.

In the last legislature, a bill was passed which related to live stock remedies, including all condimental feeds, medicated stock foods, stock-food tonics, stock powders, condition powders, conditioners, animal regulators, proprietary medicines, or any preparation of like nature in either solid or liquid form, designed for any animal except man, and administered internally for their stimulating, invigorating, curative or other powers. This law requires that any importer, jobber, firm, association, corporation or person who shall sell, offer or expose for sale or distribute in Kansas any live stock remedy, shall file for registration with the Director of the Agricultural Experiment of the Kansas Agricultural College a statement that he desires to offer such a remedy

for sale in this state. Also a certificate, the execution of which shall be sworn to before a notary public, or other proper official, stating: First, name and principal address of manufacturer or person responsible for placing such live stock remedy on the market; second, the name, brand or trademark under which the remedy is to be sold; third, the minimum net contents of the package, lot, or parcel of such live stock remedy, and fourth, the English name of each ingredient used in the manufacture of remedy registered, and it is further provided that when any of the substances are of an especially active or poisonous character, such as opium, belladonna, nux vomica, ergot, strophanthus, etc., such ingredients must be stated on the certificate; also that when such substances as common salt, charcoal, sulphur, earth, elevator dust, etc., are used as filler the maximum percentage shall be stated.

This act, thus recently passed, is very significant and it leads to the reiteration of the statement frequently made that we are more careful of the protection of the lower animals than we are of the protection of our human brethern and children. It would seem to one who is at all interested in this subject, that physicians and pharmacists together should, at least, make a strong effort in the direction indicated by this recent legislation—namely to apply the principles of this law—which are the underlying principles of standardization, to human tonics, powders, conditioners, regulators and all so-called medicines concealed in attractive cartoons and packages, the ingredients of which are so concealed as to make it practically impossible for even the pharmacologist to judge of their merit. Both pharmacy and medicine should take hold of the subject with courageous hands, and by degrees control this traffic. It is not enough to condemn the practice and products of the nostrum vender on paper. It is gratifying to report in connection with this subject that the American Pharmaceutical Association is now contemplating the scheme of cooperation with the Council of Pharmacy and Chemistry of the American Medical Society in establishing a laboratory and to determine whether certain proprietary medicines are legitimate—whether in the whole the public is benefited or injured by such ready-made medicines. and whether it is possible to draw a distinct line of demarkation between legitimate and illegitimate remedies. The settlement of this question is in the line of standardization, for the broad application and advocating of which this paper is presented.

THE JOURNAL OF THE Kansas Medical Society.

JAMES W. MAY, - - - - **EDITOR.**

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal owned by Dr. James W. May. It is now printed in Kansas City, Kansas and appears the first of every month. Correspondence should be addressed to the editor, Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President, Dr. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, Dr. J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, Dr. L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

A copy of The Bulletin of the American Medical Association will be regularly mailed to every county secretary who sends in his name to the secretary of the American Medical Association. This is a bi-monthly publication that is devoted to the discussion of questions affecting organization and conduct of medical societies, especially county societies. Its pages furnish a medium of interchange of ideas and plans which have proven successful in building up and stimulating interest in the work of the county society. Do not fail to send in your name. The Bulletin will prove to be a valuable assistant and may be the means of solving the problems of your work.

Every county secretary should send for this Bulletin which would be of a great deal of assistance, for its pages are replete with matters of great interest to the profession.

—o—

MEDICAL PROFESSION AND COMMERCIALISM.

Of late years, it seems that men who are eminently fitted as leaders of commerce, have by some error broken into the ranks of the medical profession.

Reference is made to the surgeon, often only self-styled, who purchases for himself a practice. This is done in several ways.

First by the much discussed practice of giving cash commissions or secretly dividing the fee. Second, by appointing men to positions such as railway surgeons in some small place providing that the appointee refer surgical cases to the one who appoints him. We can see little difference in the two methods. Their results are the same. Either method diverts the referred cases into a channel which in many cases they would not take if it were not for the bribery, or purchase price.

We hear frequently of resolutions being passed against these practices but we wonder if the burdening of existing laws, codes, etc., with resolutions will get the result or merely obscure the already existing laws and codes.

The code of ethics to which we all subscribe certainly covers the subject and it appears that it would be wiser to enforce what we already have instead of working off our energy by merely resolving. Make an example of some one. Let some one get up enough courage to get some bonifide evidence, prefer charges and try some offending member in the manner already prescribed. That will get results that all the resolving possible could not. The code of ethics is plain in Chapter 2, Article 6, Section 3.

"It is detrimental to the public good and degrading to the profession, and therefore unprofessional, to give or to receive a commission. It is also unprofessional to divide a fee for medical advice or surgical treatment, unless the patient or his next friend is fully informed as to the terms of the transaction."

Again the subject of soliciting by letter, personal interview, etc., is covered by Chapter 2, Article 1, Section 4.

"Solicitation of patients by circulars or advertisements or by personal communications or interviews, not warranted by personal relations, is unprofessional. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned."

Let's get busy and eradicate some of this. At least, drive them out of the American Medical Association ranks.

ARCH D. JONES.

"TURTLE SERUM."

Many of our readers, no doubt, have read articles in the daily press and in Medical Journals concerning the "discovery" of a new sure cure for tuberculosis by Dr. Friedreich F. Friedman of Germany and we mention it only to say that it is too soon yet to pass any definite opinion upon this treatment.

Dr. Friedman has been severely criticized by most of the American Medical Journals, and perhaps his attitude since reaching our shores has justified such criticism, but we should not forget that most every decided advance in medicine and surgery has invariably been met with a pessimistic welcome and no doubt the benefits of such advance have been retarded thereby. If the Berlin professor has a cure for even the incipient tubercular cases he has a real cure as in the course of time the advanced cases would disappear.

Time alone can establish the real worth of the "turtle serum" and while it is often wise to warn against all seeming fraud let us be rather reticent and hopeful than too eager to criticize and condemn.

H. B. C.

"FEE SPLITTING."

Special attention is directed to an article which was read at the state society meeting, and appeared in this Journal last month, entitled "The Surgical Situation in Kansas from the General Practitioners Standpoint," by Dr. T. A. Jones of Liberal.

From the manner in which this paper was received and discussed it was just about the "hit" of the whole meeting and to our minds this means that the doctors of the state are becoming tired of the present condition of affairs relative to fee splitting and will welcome a radical reform. One doctor in discussing this paper went so far as to suggest that he would hereafter make the fee with his patient and then employ a surgeon himself to do the work, thereby doing away with any business transaction between the surgeon and the patient.

Whatever the remedy may be we hope that the day is not far off when such a thing as secret division of fees will be unknown and unthought of, at least, by any member of our society. H. B. C.

"INSIDIOUS LOBBYING."

When Senator Owen the father of the bill to create a "National Department of Health" was on the witness stand before the committee investigating the "lobby" at the Capital he did not fail to tell that a powerful "lobby" by the "Patent Medicine Trust" and the "League" was in cooperation against his bill. This has been known to the medical profession all the time and we are especially glad of the opportunity to have the spot light thus turned upon the operation of these lobbyists that the country at large may have some idea of the cause of so much opposition to Senator Owen's bill.

H. B. C.

The annual meeting of the American Medical Association held at Minneapolis, June 17-20, was a success in every particular. The meetings were held in the halls of the University of Minnesota, and the very atmosphere of this temple of learning was favorable to success. The section meetings were said to be of more than passing interest, and especially was this so of the section on surgery, which had a program filled to overflowing with papers and discussions by the leaders in this department of practice. The scientific exhibits were way above those usually shown and this was particularly true in the department of bacteriology and pathology. At the meeting of the House of Delegates, Kansas (entitled to two delegates) was well represented by Dr. Geo. M. Gray and Dr. J. T. Axtell. The entertainments were splendid; the ladies being especially well provided for with automobile trips, visits to country clubs, bridge parties, teas and musicales. The reception to the president as usual was packed and the reception line as long as ever. The ball which followed re-awakened the dancing spirit of many old-timers who fought shy of the "turkey-trot and the bunny hug." On Thursday evening, St. Paul (Ramsey County Society) entertained with a vaudeville show, smoker and ball and this event stood out very prominently in the list of entertainments. Clinics were held by several "notables" before and after the meeting; a large delegation journeying to the Mayos' at Rochester. The following officers were elected:

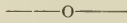
President, Dr. Victor C. Vaughan, Ann Arbor, Mich; First Vice-President, Dr. Walt P. Conaway, Atlantic City, N. J; Second Vice-President, Dr. Frank C. Todd, Minneapolis; Third Vice-President, Dr. Lillian H. South, Bowling Green, Ky; Fourth Vice-President, Dr. Sol G. Kahn, Salt Lake City, Utah; Secretary, Dr. Alexander R. Craig, Chicago (reelected); Treasurer, Dr. William Allen Pusey, Chicago (reelected); Trustees: Dr. W. W. Grant, Denver; Dr. Frank C. Lutz, St. Louis; Dr. Oscar Dowling, Shreveport, La, and to fill the term made vacant by the death of Dr. Daugherty, Dr. Thomas McDavitt, St. Paul, Minn.

The society will meet next year at Atlantic City, an ideal meeting place.

Those registered from Kansas at the meeting are as follows: ,

Boone, William M., Highland; Crumbine, S. J., Topeka; Glasscock, Samuel S., Kansas City; Gray, George Morris, Kansas City; Hassig, John F., Kansas City; May, James W., Kansas City; Peak, F. Pratt, Decorah; Wilhoit, J. C., Manhattan; Williams, C. L., Topeka; Faust, J. Wesley, Kansas City; Haury, Samuel S., Newton; Jameson, C. H., Hays; Jury, Herbert Wm. Chaffin; Kimble, T., Miltonvale; Love, R. S., Athol; Love, John E., Whiting; Maxson,

D. W. Toronto; Menninger, C. F., Topeka; Miner, Elmer A., Independence; Morrison, J. H., Independence; Nave, H. A., Kansas City; Sawtell, J. E., Kansas City; Skinner, John O., Great Bend; Smith, A. J., Leavenworth; Smith, Chas. L., Independence; Speirs, G. O., Ellenwood; Speer, N. C. Osawatomie; Staat, J. H., Bushton; Stewart, Robert, B., Topeka; Sutton, Walter S., Kansas City; Thacher, M. S., Turon; Trueheart, Marion, Sterling; West, H. W., Yates Center; Axtell, J. T., Newton; Bribach, Eugene G., Atchison; Gage, G. R., Hutchinson; Koch, George L., Hoisington; Langworthy, S. B., Leavenworth; McCarty, T. L., Dodge City; Nye, H. W., Osborne; Blake, C. D. Ellis; Bieber, Karl A., Tipton; Bryan, H. R., Galatea; Coon, W. F., Coury; C. W. Reynolds, Holton.



The following article from the Bulletin Journal Animal Therapy, June, 1913, speaks the truth concerning this phase of Christian Science. It was sent in by Councillor Kenny:

RELIGIO—MEDICAL CRIMES

Nearly every experienced physician knows of at least one instance where diphtheria has killed a member of a Christian Science family or similar faith-cure cult. Every competent physician knows that antitoxin properly timed and properly dosed saves practically every case of this disease. The legalized religious murders of the inquisition are legitimately comparable in horror to some of the religio-medical murders of this progressive twentieth century. Present-day conceptions of religious liberty give warrant to legally sane adults to lose their lives for a religious delusion, but there is no law, written or inferential, which justifies these same individuals in risking the lives of their helpless unthinking children in a gamble with a joke.

If, as seems most likely, the present genuine progressivism of this country shall prove steadily progressive, legislation must ultimately separate religion from medicine. With our present enlightenment the association of religion with government would do infinitely less harm in a century than is being done now in a year by the association of religion and medicine. We have positive proof that these cults annually benefit thousands of unstable, illogical, neurotic citizens, and it is also freely admitted that hundreds of promising children are annually killed by the neglect of these agencies, and one average child is worth more to the state than a hundred hysterical incoordinates who for years have shown a hopeless instability of self-regulation.

EDITORIAL CLIPPINGS.

SUGGESTIONS FOR INCREASING INTEREST IN COUNTY SOCIETIES.

1st. Improved programs. Interest in the meeting depends largely on the attractiveness of the program.

2nd. Take up post-graduate course as recommended by American Medical Association. This systematizes the program.

3rd. Confer with State Board of Health for at least one meeting a year on public health matters. Co-operation with the Health Department is essential to the welfare of the community.

4th. Have at least one reader a year from a distance. Confer with Committee on Scientific Work of State Society if necessary. They will be glad to suggest names of those willing to render such service.

5th. Arrange for one or more clinical meetings a year. Select subject and request all who have proper cases to bring them before the society; then have a discussion on the same, always with the understanding that discussion of the case shall not be held in the presence of the patient; otherwise, frequently patients cannot be shown for obvious reasons.

6th. Arrange for demonstration by bacteriologists and pathologists with specimens, lantern slides, etc.

7th. Arrange for social part of meeting. Some light refreshments at the close of the meetings are an adjunct to fraternal intercourse.

8th. See that meetings are held often enough to keep up interest. Once or twice a year is not enough. Invite every member of the profession in the county to at least one meeting a year, not necessarily inviting them all to the same meeting. In counties where men do not show a willingness to write papers either designate writers for different meetings or see that outsiders are invited in other words, see that the meetings are made interesting. It should be the aim of every county society to secure a permanent home; a small library, with a supply of current journals, and the use of the larger libraries for reference books will greatly increase interest in the county organization.

9th. Arrange the time of meetings to accomodate the largest number of members. Where men come from long distances, an evening session will often appeal to a larger number of men when it permits them to reach their homes at a seasonable hour.

10th. Select as officers men who are willing to work. Keep good men in office. Do not promote them who have shown they

will not attend to the duties assigned them. Efficiency is the only criterion of leadership. "No physician should accept office unless he is prepared to give the position the attention that it deserves and unless he is interested in the work."

11th. In small societies do not unduly multiply offices—the secretary's and treasurer's duties can be best done by one man. Always supply officers with clerical help if work is onerous. Detailed drudgery work should not be asked of men serving others without compensation.

12th. Make the dues large enough to warrant conducting the society work in a proper manner. Those who object to the amount of their dues usually do so because they are not receiving full value for them. Give back a dollar in value for every dollar paid in and complaints will be few.

13th. Provide a committee on entertainment who shall welcome new or prospective members or guests at meetings. The officers of the society may be active or ex-officio members of such committee. Newly registered physicians should be visited by such committee or written to and asked to join the county society.

14th. Have high ideals. Be liberal, yet firm in maintenance of a high ethical standard. Educate the public. Be a power for good in the community. Do not be ashamed of the county society or apologize for it; make it better. Attend all meetings and see that others do the same. "The county society is a conservator of patriotism and worthy citizenship."—New York State Journal of Medicine.

SOCIETY NOTES.

The Butler County Medical Society met in Augusta, June 19. The following program was prepared but the unavoidable absence of Drs. Wilson and McKinney materially shortened the program.:

Paper—Mal-Formation of the New-Born, Dr. N. E. Wilson. Discussion by Dr. H. A. Hill.

Paper—Para-Typhoid Fever, Dr. Wm. McKinney. Discussion led by Dr. R. J. Cabeen.

Paper—Progress in Treatment of Rectal Diseases, Dr. H. Philipp. Discussion led by Dr. F. E. Dillenbeck.

Paper—Neurasthenia, Dr. W. W. Weber. Discussion led by Dr. W. O. Bennett.

The physicians and their ladies all took their supper together at the West & Switzer Cafe.

The evening session was a round table discussion of the fee-splitting question, participated in by all the members and a dozen

of the leading physicians of Wichita, members of the Sedgwick County Medical Society; including their president, Dr. O. W. Swope and Dr. Arch D. Jones, Councillor for the 6th District.

Both sides of the question was ably presented and advocated
We cordially extend an invitation to our visitors to come again.

J. R. McCLUGGAGE, Sec.

—o—

Program of the Harvey County Medical Society for July:

“OBSTETRICS.”

“Complications of the Third Stage of Labor.” Dr. G. D. Bennett.

“Placenta Previa.” Dr. D. G. Buley.

“Eclampsia.” Dr. R. O. Howard.

Review of Recent Literature and Report of Case. Dr. F. L. Abbey.

F. L. ABBEY, Sec'y.

—o—

NEWS NOTES

Dr. W. L. Borst of Belpre, Kansas, has sold his practice to Dr. A. C. Boyd. Dr. Borst will do post-graduate work during the summer before locating again.

—o—

Dr. Fred A. Forney has succeeded Dr. J. E. Foltz as superintendent at the State Industrial Reformatory, Hutchinson.

—o—

Dr. S. L. Axford, formerly prison physician at Leavenworth, has been appointed superintendent and physician-in-charge of the Evergreen Place Sanitarium and Hospital, Leavenworth.

—o—

Dr. James Faulkner, Lansing, has succeeded Dr. S. L. Axford, Lansing, as physician to the State Prison, Leavenworth.

—o—

OBITUARY.

Archibald Borden Sellards, M. D., Miami Medical College, Cincinnati, 1875; a veteran of the Civil War; died at his home in Lawrence, Kan., April 20, from cerebral hemorrhage, aged 68.

—o—

Herbert Whitworth, M. D., Pulte Medical College, Cincinnati, 1875; coroner, physician and health officer of Ford County; died at his home in Dodge City, Kans., May 17, aged 60.

—o—

William C. Hamilton, M. D., University of Paris, France, 1860; surgeon in the Confederate Service during the Civil War; a practitioner of Chicago until 1879 and thereafter a practitioner

of Topeka, Kans., died at his home in that city, May 11, from paralysis, aged 74.

—o—

Theodore Wing Peers, M. D., University of Michigan, Ann Arbor, 1885; emeritus professor of diseases of children in Kansas Medical College, Topeka; a member of the Kansas Medical Society; died at his home in Topeka, May 12, from cerebral hemorrhage, aged 56.

—o—

The Journal of Kansas Medical Society:

I wish to report the death of William Dio McPhee, aged 42, graduate Kansas Medical College, Topeka, 1890; several years practitioner at Anthony, Kansas; committed suicide by hanging himself at his home June 8, after suffering a number of years from melancholy.

W. L. GALLAWAY.

—o—

REVIEWS.

Present-Day Uses of Vaccines—Theobald Smith, Boston (Journal A. M. A., May 24), after prolonged study and investigation of the methods of producing immunity from infectious diseases, discusses at length the present-day uses of vaccines. Premising that facts for immunization from disease, or rendering them of milder type, were known to the Chinese thousands of years ago, he says that since Jenner's discovery and later, Pasteur's time, new methods for inducing immunity have been successfully evolved by succeeding generations. Continued attempts to modify viruses and make them as harmless as possible are being made, and so satisfactory have been results that the use of vaccines is no longer limited to prevention but is now carried to the very heart of disease itself. To evaluate the present-day status in experimental medicine and to suggest possible means and aids to further inquiry and discovery is the avowed object of his paper. He suggests, as an important aid to further accomplishment in the domain of preventive medicine, the study of the natural history of infectious diseases; an inquiry into Nature and her laws, and a study of the ultimate results in one attack of a given disease and just how the system rids itself of an infecting agent. The body makes different response and resistance to different infectious diseases; hence, each group will need to be studied by itself. Accepting the fact that it is possible to raise the level of resistance to an infectious disease by artificial means, he reviews the methods used beginning with Pasteur who favored use of living virus of a disease as a vaccine. Acknowledging that they had proved superior to heated

ones for securing immunity, yet he thinks there is an element of danger involved in their use which may become apparent at any time. Living vaccine may prove too virulent and cause genuine disease, and the vaccinated become carriers.

So-called sensitized viruses, the author thinks, should receive more attention, and explaining why a neutral mixture is more effective than pure toxin, he says the toxin mixed with the anti-toxin penetrates the body while the former is mostly retained at place of puncture. Directing attention to the reciprocal relation between pathogenic micro-organisms and their specific host, he emphasizes the need of studying every infectious disease by itself and the keeping of the principle of active immunization carefully and constantly in view. Vaccination for typhoid should have a thorough test but not be allowed to take the place of those precautions heretofore held as essential in combating it. Vaccines are now used in affections in which the specific agents are frequently detected in the blood and in which the symptoms plainly show that the infection is general. Medical science is therein at a disadvantage because the types of disease in which they are used are not reproducible in the laboratory. He views with misgiving the commercialization and indiscriminate use of vaccines and enjoins the profession to see to it that vaccine therapy does not degenerate into reckless experiments on human beings. To this end the student should be influenced and given opportunity to grasp the scientific method and gain a critical attitude toward old and new alike. Concluding, he thinks vaccines applied during disease will be rarely, if ever, life-saving but they may hurry processes that lead to recovery, vivifying unused reserves in the tissues.

—o—

MISCELLANEOUS.

THE TRUTH ABOUT DR. FRIEDMANN.

Dr. J. L. Grove, Who Is In Berlin Writes His Views.

WHAT BERLIN THINKS.

Experiments Described In Laboratory Research Work.

The following article is extracts from a letter written by Dr. J. L. Grove, now specializing in surgery in Vienna. The Kansan had requested Dr. Grove, when it was known that he intended to make a study of the tuberculosis serum while in Berlin, to write home a letter that the Kansan readers might read. This letter was written to home folks and extracts made by Dr. Axtell and

read at the Harvey County Medical Society meeting, held Monday night. This tells of Dr. Grove's laboratory work in Berlin, of tests made with the turtle serum on guinea pigs, also humans and of his opinion of Dr. Friedmann:

It is no easy matter to arrive at just conclusions or secure for yourself an unprejudiced opinion in reference to the latest knowledge along the lines of treatment for tuberculosis, here in Berlin. Friedmann seems utterly without professional support outside of his own office force. When such men as Bier, Pick, Westenhoeffer and others who are leaders in medicine here brand him as a grafter and renounce his methods before the Berlin Medical Society, it is hard not to fall in line. Yet, when one carefully analyzes the statements these men make, the condemnation is not so much on the treatment, as on his methods of exploiting it, both here and in America. Throughout, his methods have been purely selfish and with personal and financial gain always first. Further, this selfish motive of Friedmann has lead him to bring out this treatment before it had been sufficiently tested clinically. Possibly, I might better say the clinical test of various investigators had not been compiled, compared or checked up by each other. You know, it takes the other fellow to pick flaws in your work. There has been during the past several years a number of bacteriologists of reputation, quietly working on the turtle serum here in Berlin. I do not believe they had chosen Friedmann to exploit the cure. Dr. Friedmann quit his work over Professor Orth's laboratory and started one of his own. He locked himself and his work in, not even allowing his rooms to be cleaned, and then without his work being checked up or verified by others he begins the "show." It looks to me as though Friedmann stole the other worker's fire. He is doubtless a little premature in his exploitation.

Now as to the treatment: For sometime, of course, we have known of the existence of tuberculosis in animals and birds, cattle, chickens, rabbits, fish, turtles and snakes all suffer from the ravage of the disease and the germ found to be the specific cause is much the same in each case. All are acid fast, i. e., when stained with a certain dye, preparatory to examining with the microscope, they will hold the dye color even when washed in weak acid, which removes the color from other types of germs. Then too there is some difference in size, for instance the turtle bacillus is only $\frac{1}{4}$ to 1-6 the length of the germ which affects man. Further difference is shown when the germs are grown on artificial media. Here the tuberculosis germ multiplies very much more rapidly than the human type. Yet these germs are all tubercle bacilli producing,

in the respective animals a disease which we know to be tuberculosis.

Now the chief difference which has to do with the very essence of the cure. I can best explain this by giving one of the experiments which we have carried out in Dr. Piorkowski's laboratory. By the way, three of us, a Canadian, a New Hampshire man and myself are getting a private course under this professor. He is the man who is furnishing Dr. Heit of Pittsburg with the serum. He showed us a cable from him asking for more serum and telling of very good results in five cases, one of them being in his wife, that he is treating. Eight guinea pigs were given doses of very active tubercle bacilli. After ten days when they were all very sick, not eating and showing fever six of them were given doses of turtle serum. Two days following the two not given the serum died and were found full of miliary tuberculosis. Lungs liver and glands were especially affected. The other six were beginning to eat and temperature going down from three to four degrees above normal to one-half to one degree above.

After another week we killed two of the six and on post-mortem we were unable to locate a single tubercle. The rest of the pigs, after a few days, have had normal temperature and seem perfectly well up to date. Just what became of the tubercles, how or why they were absorbed, and they must have been, and eliminated from the pigs so treated, I'll not try to explain, although they have a few theories here. The fact remains they were dissolved and the pigs so treated are apparently well.

Now as to the work we have seen in the hospitals. Over two hundred babies in the children's wards of the Charity Hospital, all showing active tubercular tendency, all from tubercular parents, were given very small doses of Piorkowski's live turtle serum as an immunizing dose. While these babies were the usual poorly nourished unresisting kind found in large public hospitals, without a single exception they have failed to show a bad result from the injection, no swelling, no abscess, and nearly every case has shown marked general improvement. We have seen quite a number of adult cases, of tubercular bone disease and skin tuberculosis, which have made very marked improvement under the treatment. It is more difficult to note changes in adult pulmonary cases although a number which we have seen report themselves as feeling better, less fever and absolute cessation of night sweats. Altogether Piorkowski reports to us that the physicians working with his serum have given over 500 doses and have up to date no bad results to report.

From the foregoing you can see that the live serum from the cold blooded animals seems to have a peculiar antagnoistic effect for the live human tubercle bacilli. If the men who are working here, and there are a number of them, will soon make public their results, get them in shape to guide the careful practitioner who has not the wonderful clinical opportunities offered here, there can be no doubt in my mind that another long step will be taken toward combating the dread disease, tuberculosis. Dr. Friedmann's rash outbreak will certainly delay the general sane use of live turtle serum and no one should believe for a moment that advanced cases of destructive tuberculosis can be restored again to normal health, by the use of it or any other remedy so far known.—The above is from *The Kansan*, Newton, Kansas.

CLINICAL NOTES

Pyelitis in Infancy—The recognition of pyelitis in childhood is usually easy, and yet it is overlooked again and again simply because of the possibility of its occurrence is forgotten and the urine of an infant is seldom examined. Unrecognized acute pyelitis in infancy gives rise to prolonged severe fever, with profound constitutional disturbance, which may be fatal. Recognized and treated appropriately, it often subsides in a few days, and even if symptoms persist for a time they quickly become less severe, and generally soon yield to treatment.—Geo. F. Still in *Pediatrics*.

“Pregnant women who have the clinical history or reveal symptoms of syphilis may be submitted to the salvarsan treatment intravenously, and such treatment repeated at varying intervals, care being exercised to avoid too severe a reaction. The intervals between treatments may be longer than in the ordinary run of cases, and the course made to cover a period of four to six months.”—C. H. Chetwood, of the New York Polyclinic Medical School.

Diagnosis of Peritoneal Effusions—With the patient lying on his back in peritoneal effusions of moderate or small quantity, there is always fullness of the flanks, the degree of fullness depending not only on the quantity of fluid, but also on the relaxation and thinness of the abdominal wall. If the abdominal wall is relaxed there is always more or less flattening of the abdomen anteriorly; if the walls are tensely distended this appearance is obscured. If there is much subcutaneous fat the fullness is even more greatly obscured; edema will also obscure it.—A. McPhedran in the *Canadian Medical Association Journal*.

THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, AUG. 1913.

No. 8

THE GALL-BLADDER.

E. E. HUBBARD, M. D., C. M., Shawnee, Kansas.

Read before the Kansas Medical Society, May 7, 1913.

It has always seemed to me that the only excuse one ought to plead for appearing before an assembly of this kind, is, that he has something to say, or that he has a new and more lucid way of saying something that may simplify. I shall plead an attempt at simplifying.

It will be merely killing time to presume to tell you where the liver and gall-bladder are located, so I will not affront your intelligence by such a rehearsal, but merely state that we expect to find the gall-bladder in the right para-sternal line at the lower margin of the ninth costal cartilage.

In spite of expectations we meet abnormalities such as total absence of the gall-bladder either congenital or as an effect of inflammation.

I have met one case of absence of the gall-bladder in a case of carcinoma of the liver which seemed to have been congenital.

We may meet cases of double gall-bladder, one on the left lobe and the other on the right lobe of the liver.

The gall-bladder may be deeply imbedded in the substance of the liver, the fundus showing through the anterior surface like a cyst.

Normally the gall-bladder lies obliquely on the inferior or visceral surface of the liver, directed from below upward and backward to the left, the lower dependent end being the fundus and tapers upward and backward into the cystic duct.

The fundus usually comes in contact with the anterior abdominal wall. The gall-bladder is a fibro-muscular sac, lined with mucous membrane and covered on its outer surface with peritoneum which covers its entire surface, except perhaps one third

where it comes in immediate contact with the substance of the liver.

The fundus of the gall-bladder may not be covered with peritoneum in cases where it is empty and contracted above the margin of the liver. Its wall contains blood-vessels and nerves but is practically devoid of lymphatics.

There is very little to be said of the embryology of the liver and gall-bladder except that it is developed from an eversion of the ventral wall of the primitive gut just below the eversion producing the pancreas.

From the eversion or bud producing the liver is another diverticulum producing the gall-bladder and cystic duct; so they are each a part of the other, the common duct representing the pedicle of the original diverticulum, at the distal end of which the liver has developed.

The length of the gall-bladder is about three inches, its diameter about one to one and a quarter inches, with a capacity of about thirty to forty-five c. c. It distends readily and may be made to hold 250 c. c. without rupture. Cases are on record in which the distended gall-bladder has been mistaken for an ovarian cyst.

The gall-bladder may be in contact with the first portion of the duodenum, the pylorus, the body of the stomach, or it may be depressed and in contact with the colon or anterior surface of the right kidney.

The causes of these variations, are, distended colon, which pushes the gall-bladder upward, enlargement of the liver, hepatitis, tight lacing, distention of the stomach and enlargement of the left lobe of the liver.

The cystic duct begins at the neck of the gall-bladder and runs over an irregular course backward and inward and joins the hepatic duct to form the common duct.

The cystic duct leaves the neck of the bladder at its inner side above its lowest point as a means of preventing pressure of the stored bile coming directly on the sphincter.

The common duct, formed by the union of the cystic and hepatic ducts continues its course downward and toward the left behind the duodenum and enters the duodenum obliquely through its wall, into the ampula of Vater in common with the pancreatic duct. The function of the gall-bladder is not understood. Some have presumed that the mucous glands in its wall added something to the bile but there is no evidence to that effect, except that they add lime in the formation of stone.

It has been supposed to be a reservoir, but that does not seem

very reasonable because its capacity, one and one-half ounces, is entirely inadequate to the requirements, the daily discharge of bile being in the neighborhood of two pints. I am inclined to the idea that the gall-bladder is intended as a pressure valve, because of the muscular structure of itself and duct. We get a hint in this direction from a few observations that opportunity has afforded, which show the stump of the cystic duct dilated to quite an extent after removal of the gall-bladder and major portion of the duct.

The common duct has been seen dilated to a good degree after removal of the gall-bladder and cystic duct, thus making it seem that an intermittent pressure is required, more than the mere force of gravity or the vis-a-tergo of the bile itself.

The function of the gall-bladder is not very important, judging by the fact that its removal causes no inconvenience.

Of the diseases of the gall-bladder, gall-stone disease is the first to recur to one's mind because of its prevalence.

Stones are found in the gall-bladder in ten per cent of all cases at necropsy or operation. Gall-stones are presumed to remain dormant in many cases, never producing symptoms, but they probably always do produce symptoms if we are acute enough to interpret them.

We begin to get hints of gall-stones from Hippocrates and Galen by way of mention of "pain in the hepatic region" and "icterus as a result of constipation."

Stones were probably found in the gall-bladder for the first time in the 14th Century. The first definite mention of gall-stones was by Antonius Benivenius who died in 1592.

Since then many observers have found stones in the cadaver and in feces. The last few years have shown the commonness of gall-stones. Morgagni discovered glands in the wall of the gall-bladder which helped to explain the pathology of gall-stones.

The origin of gall-stones has long been sought; Galen's original idea that prevailed for a long time, was, that gall-stones were formed from coagulation of the bile due to an increase of the temperature of the liver.

Paracelsus and others since have supposed that the acidulation of the blood from indigestion and other causes acting on the bile caused precipitation. A later idea was that catarrh of the bile passages caused a precipitation of calcareous matter forming stone.

Austin Flint and Dujardin-Beaumetz theorized that cholesteræmia followed nervous work and cerebral activity leading to the idea that gall-stones were formed as soon as abnormal quanti-

ties of cholesterin were poured into the blood. The coagulation or inspissation theory of gall-stone formation is pretty thoroughly contradicted by the fact that we know that the bile may remain in the gall-bladder by occlusion of the cystic duct and no inspissation or precipitation occur, but, that hydrops of the gall-bladder occurs. Naunyn and his pupils, have in the last few years made a good deal of advancement in this line, and a summary of their work seems to lead to the old catarrhal inflammation theory. Naunyn says the bile in the gall-bladder always contains desquamated epithelial cells from the mucous lining. As a rule these cells show no degenerative changes, but in the old, and in the tuberculous, in febrile cases and in cases of cardiac lesions there is found at necropsy, a state of fatty degeneration of the epithelial cells, especially if gall-stones are present in the gall-bladder.

Within these cells are found small and large droplets of fat or myelin; these collect outside the cells into small balls of myelin which is chiefly cholesterin. There are hard crystallized particles among these at times, and again there are heaps of granular, brownish rubbish; about these forms a shell of cholesterin and other layers are formed, and thus little stones grow large. Many times there is a shell enclosing a large collection of these little balls of myelin, forming a granular, mushy center. We are at liberty to assume that bile stasis occurs in all of these cases to some extent as an aid to these formations.

Age and vitiated nerve function produce atrophy of the muscles of the biliary apparatus, thereby producing stagnation by loss of peristalsis. The different layers of these concretions either consist of pure, white cholesterin or cholesterin mixed with bilirubin or bilirubin-calcium. This latter mixture is colored; the layers of pure cholesterin are thinner than those containing pigments.

Cholesterin stones can form in an isolated gall-bladder but the pigment deposits cannot occur unless the bile comes in contact with the stones.

The old view that cholesterin is deposited after ingestion of large amounts of fat is no longer tenable.

Cholesterin forms about one per cent of the solid constituents of the bile, has little importance in general metabolism and physiology, and is important only in biliary concretions.

It is not a product of hepatic secretion, and is present in the blood in only minute amounts. Cholesterin found in the bile-ducts and atheromatous cysts must be considered a product of disintegrated epithelium. Disintegrating liver cells may be a

source of cholesterin, Austin Flint's cholesteræmia being no longer reasonable.

After all that has been said we are at liberty to assume that a diseased condition of the mucosa of the gall-bladder and bile-ducts leading to increased cholesterin production, is the primary cause of gall-stone formation.

Guinette noticed two kinds of gall-stones, blackish ones and yellowish-brown ones. The dark ones are hard and heavy and incombustible while the lighter ones melted and burned in the flame.

According to modern chemistry the former consist of bilirubin-calcium and carbonate of calicum. The lighter ones consist of cholesterin. Cholesterin and the bilirubin-calcium compounds are more or less equally mixed. The stone is built up of concentric rings of these materials of varying color, according to the varying amounts of bile pigment present. The nucleus is generally soft while the outer layers are hard.

There is generally a radiating structure discernable, first described by Morgagni, and was attributed by Meckel to the peculiar manner of crystalization of the cholesterin content of the stone.

There is a small amount of several elements found in gall-stones at times, but they are not more than mere traces.

The color of the stone depends on the quantity and character of the pigment present. The nearly pure cholesterin stones are almost snow white. The consistency will depend on the composition; the greater the quantity of calcium compound present the harder the stone will be. Cholesterin stones are very soft and light. The shape of the stones differ according to their place of origin and number.

If there are a small number of fair sized stones in the gall-bladder there doubtless will be facets produced by pressure upon each other during their plastic stage. They may be very irregular in shape and size, even extending into the various ducts and passages; and they may be very numerous and as small as grains of sand. The diseased condition of the mucosa of the gall-bladder referred to above leads us to the question of the causes or source of the diseased condition or inflammation which leads to the production of a superabundance of cholesterin and thus to gall-stones.

There seems but one possibility, or at least probability, in this direction; that of hematogenous infection by way of the portal circulation and irritating toxic material in the bile. The history of cases gives us an idea in this line. It is known that many cases of chole-lithiasis and chole-cystitis give a history of typhoid fever. It is pretty well conceded that infection does not enter the gall-

bladder from the duodenum but from the portal circulation to the bile ducts and thus come to the gall-bladder in the bile in a backward flow through the cystic duct producing inflammation of the duct before the gall-bladder is reached in many cases. From these ideas we can readily presume that infectious diseases may always be the fore-runners of gall-stones or cystitis and that we may always have a cystitis which in the great majority of cases subsides voluntarily.

We may also reasonably suppose that chronic constipation is a possible cause of chole-lithiasis and chole-cystitis, for the above reasons, i. e., that the entire portal circulation passes through the liver and the rubbish is filtered out and remains to be ejected with the bile. Appendicitis is often a fore-runner of gall-bladder trouble. This propounds the perennial question, "the cause of appendicitis."

We are aware that the ileo-caecal region is the most bacteria infested region of the whole alimentary canal; then why should we wonder that any disease should miss this site? It is not therefore, surprising that the blood might convey to the liver and gall-bladder all varieties of infections and toxines. Observers have noticed that women are more frequently subjects of gall-bladder disease than men; the general agreement is about three to five times as many, due to sedentary habits, relaxed abdominal parietes, tight lacing and resultant constipation. We can presume that gall-stones may form in a very slightly inflamed gall-bladder and produce symptoms hard to differentiate and that a more acute inflammation may develop at any time because of the irritating presence of the calculi aided by the ever present bacteria. This cystic inflammation may be very severe and even purulent and produce no signs of infection, no fever, and no blood picture because there are virtually no lymphatics in the wall of the gall-bladder and therefore no absorption. Purulent inflammations are less often met with than fibrinous inflammations but the more active processes may include the whole cyst wall including the peritoneal covering, and cause adhesions to all contiguous tissues.

Symptoms in acute cases are sudden violent onset of pain, sharp and paroxysmal at the gall-bladder site, or epigastrium, remittent in character, at first diffuse, later localized, accompanied by great tenderness and muscular rigidity, nausea, vomiting and prostration; pulse usually rapid, temperature high, chill may occur immediately or later; jaundice is not present. Tumor is usually absent, but when present is smooth, symmetrical, tender, tense, nonfluctuating, tympany in fulminating cases, constipation ab-

solute. Treatment is absolute rest in bed and heat internally and externally with opiates and operation as soon as the acuity of the inflammation has subsided reasonably.

Primary cancer frequently develops in the gall-bladder as a result of chronic irritation caused by gall-stones and inflammation.

Musser collected one hundred cases of cancer of the gall-bladder. Cancer of the gall-bladder, like gall-stones is several times more frequent in women than men, and cannot be diagnosed early, and can be successfully combatted only by operating early in cases where any gall-bladder trouble is diagnosticated, as about 75% of cases of malignancy in this neighborhood are found in the gall-bladder. Cancer of the cystic and common duct is not rare but practically always secondary and generally of the slow growing scirrhus variety. I shall not go into the symptoms and diagnosis of late cancer of the gall-bladder and ducts because I am advocating early diagnosis and operation, which can be arrived at only by operating early, on the first reasonable suspicion of inflammation or stone.

As to symptoms, Leilienthal thinks that indigestion with or without pain, especially after eating meat; in the absence of emaciation and jaundice, it is reasonable to suspect gall-stones of large size because large stones do not obstruct the duct, and therefore do not interfere with the escape of bile into the duodenum.

Leilienthal's ideal gall-stone patient is a woman in the early forties, a gormand, does not masticate her food, is rapidly growing obese, neglects her bowels, and has emotional crises. Lichty says that gastric analysis indicate hyperacidity in only 53% of gall-bladder cases and gastric motility is disturbed in about the same proportion. I have already mentioned that temperature is not a criterion because even in empyema the temperature remains near normal in 50% of cases because the absence of lymphatics in the gall-bladder wall admits of no absorption. If the bladder is so distended that the cystic duct is encroached upon, there will be absorption and temperature because of the presence of lymphatics in the duct wall.

Chronic indigestion of some degree will always be a part of the history and perhaps a large part. Pain after meals is a characteristic thing, appearing usually in the night three or four hours after the evening meal, is intermittent, paroxysmal and sudden, and subsides suddenly.

Pain is caused by the passage or attempted passage of a stone out of the bladder and during its passage down the duct. Pain is very severe, showing all the signs of nervous shock; convulsions

are often seen, and patients have died in agony during the paroxysm. It is probable that inflammation is the cause of the pain.

There will always be soreness in the gall-bladder area after an attack of any degree, and a tender area in the back over the last dorsal and first lumbar spine because of the connection of the spinal nerves from the last dorsal and the first lumbar segment of the cord supplying the area of the gall-bladder and contiguous territory.

If bile is retained, there will be jaundice, clay colored stools, constipation and bile in the urine. Kehr says history is the best guide to diagnosis, for physical findings are generally negative. He says he could palpate stones only three or four times in four thousand cases.

The gall-bladder may become dilated from various causes, as stone in the cystic duct, tumor of contiguous structures pressing upon the duct, or tumor of the duct itself, or adhesions from inflammations in the immediate neighborhood causing constrictions.

The dilated gall-bladder is not very palpable and cannot be easily diagnosed although it may become so distended as to extend several inches below the margin of the liver.

A very large gall-bladder may become twisted on its axis and become gangrenous, but discussions and diagnosis of dilated and twisted gall-bladders are better engaged in at operation or necropsy, and operation should be undertaken early to anticipate complications.

Tuberculosis and actinomycosis of the gall-bladder are seen occasionally.

There has been not a little discussion as to the necessity or otherwise of immediate operation in cases of chole-lithiasis and chole-cystitis, some claiming that waiting is harmless. It must be remembered that the first attack may be fulminating and end in peritonitis and death; and a mild attack may be followed by a severe one.

Mayo says that operation should be done as soon as a diagnosis can be made and that every argument for early operation in appendicitis applies with the same force in gall-stones. The contra-indications are the same as in other cases, especially hemorrhage in jaundice when due to cancer.

I have not had in mind an attempt to detail the technic of operation in these cases, but to point out some of the reasons for common conditions and the reasons for interfering surgically, as well as the urgent need of early work before degenerations have caused fatal havoc with a large amount of tissue.

It seems to me that the terrible fear of the knife, especially by the general practitioner is no longer excusable, as operation is the only means of escape from a dilemma that will never grow better by expectant treatment or the use of drugs.

—o—

PSEUDOLEUKEMIA.

DR. RALPH H. HERTZLER, Newton, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

Although pseudoleukemia simulates leukemia by its clinical course, the appearance of the patient, and the anatomical findings still it is characterized by the variability of the symptoms and the absence of the white blood corpuscle sign. It is a rare disease usually resulting in chronic anemia, and is accompanied by a general hyperplasia of the lymph structures throughout the body, and the growth of lymphoid tissue in the spleen, liver and other viscera. It is progressive in its course and as a rule fatal.

The uncertainty of the clinical picture is well illustrated by the various other names under which other conditions closely simulating pseudoleukemia are grouped; adenie, Trousseau; lymphosarcoma, Virchow, Langhans; malignant lymphoma, Billroth; lymphatic or splenic anemia, Greisinger, Strumpell. In 1802 Hodgkin published clinical observations on glandular and splenic hyperplasia which produced general manifestations; however, leukemia as a clinical entity was not yet discovered at that time and his writings therefore did not refer to a uniform affection.

Pseudoleukemia was formerly differentiated as pseudoleukemia lymphatica and lienalis, according to the principal enlargement. Pseudoleukemia medullaris was added later on, but according to more recent investigations the primary origination from the glands is very much more frequent; and according to Neumann and Grawitz exclusive localization in the spleen is rare, while an affection of the bone medulla leads usually to leukemia. After some investigators had discovered tubercle bacilli in pseudoleukemic swellings, C. Sternberg, published observations to the effect that 15 to 18 closely observed clinical cases were tubercular, in which microscopic examinations showed a difference from true lymphomata by special cells and caseation. Grawitz maintains however, that it is not always possible to clinically differentiate these tubercular enlargements and true pseudoleukemia, that both groups may be equally influenced by arsenic and he therefore makes the etiology the basis of the classification—pseudo-

leukemias of a simple lymphomatous, tuberculous, and syphilitic origin. Generally speaking, the usual symptom is the clinical picture, namely, the progressive hyperplasia of all the lymphatic structures.

Occurrence—Although youthful individuals are principally affected, pseudoleukemia is exceedingly rare in childhood. It is more common in males than females; 75% in males between the ages of 20 and 30 years.

Etiology—The etiology is not clear. It may occur after local lymphatic disturbances in the neck following otorrhoea, coryza, resection of the glands of the neck, tonsillitis, also gastric disturbances, defective teeth; supposedly after malaria, whooping cough, dysentery. Occasionally it runs in several members of a family. Its true nature is unknown. The frequency of an associated temperature, the cervical gland enlargement and the not infrequent primary tonsillar involvement, the often rapidly fatal termination suggest an acute infection. The results of bacteriological study are uncertain.

Morbid Anatomy—The most extensive and apparent involvement is in the superficial lymph glands; the cervical glands becoming first enlarged and forming continuous chains with the mediastinal and axillary glands. The glandular masses may be found under the pectoral muscles and scapulæ. The inguinal glands are usually enlarged in a continuous chain from the retroperitoneal glands. Of the internal glands the thoracic groups are most frequently affected. The trachea and aorta may be surrounded and veins may be compressed. They may perforate the sternum and deeply invade the lungs. They may compress the iliac veins and nerves and the ureters. They may adhere to the uterus and broad ligaments, simulating fibroids.

The jugular veins may be surrounded and compressed; the glandular enlargement often passes to the intra-thoracic glands causing dyspnea, compression of the superior vena cava, dysphagia and recurrent pharyngeal and vagus nerve paralysis.

The glands primarily are soft and elastic, perfectly discreet, round or oval and clearly palpable; later they become hard but always easily palpable as separate and distinct glands as fusion does not occur. The gland never bursts the gland capsule, the capsule is not infiltrated and there is no invasion of the surrounding tissue. They seldom caseate or suppurate. They may sometimes be slightly painful.

The spleen is enlarged in 75% of the cases, according to Gowers.

The marrow of the long bones may be changed to lymphoid tissue. The lymphatic structures in the nose and throat may enlarge causing obstruction, difficult respiration, snoring and mouth breathing.

Blood Picture—In the early stages of the disease the blood may show no appreciable change. There then follows always a certain amount of anemia which may become severe. Poikilocytes often occur. Nucleated erythrocytes are frequent. The ratio between the red and white cells remain normal. The hemoglobin is decreased but the color index remains stationary at 1. There is usually a relative increase of lymphocytes. The polymorphonuclear neutrophils are decreased. The total white cells are not necessarily increased; in fact, frequently a leukopenia is present. Eosinophilia is occasionally an important diagnostic finding.

Course—An acute form of pseudoleukemia is not definitely established. Some apparently acute cases are simple acute exacerbations of a long standing disease. The clinical course is usually long. Occasionally long intervals of comparative health occur. The glandular swellings may decrease with or without treatment. Death may occur from some intercurrent affection, such as tuberculosis or pneumonia, but it more often results from chronic cachexia and asthenia. Obstruction of the air passages occurs. Death may also follow twisting of pedicle of spleen, or from hemorrhage from the nose, larynx or from the various viscera. Seldom does a transition into leukemia occur. Permanent recovery from a well developed pseudoleukemia is questionable.

Fever—Fever is usual. Several types occur (1) A slight irregular fever, (2) there may be a daily rise of three or four degrees with chills or sweats, (3) an intermittent fever of 10 to 14 days duration, alternating with intervals of apyrexia. When the disease involves the internal glands only, the fever may simulate typhoid. Fever is often indicative of tuberculosis or of some terminal infection.

Cutaneous Symptoms—Intense itching of the skin, loss of hair, bronzing of the skin, lymphadenomatous nodules under the skin, erythema, purpura, all occur more or less frequently.

Nervous Symptoms—Occasionally symptoms suggesting tabes occur. Hemiplegias, loss of patellar reflexes, paresthesias are accompaniments.

Diagnosis and Differentiation—It is necessary to differentiate pseudoleukemia from the following important conditions, (1) glandular tuberculosis, (2) leukemia, (3) lymphosarcomatosis, (4) anemia splenica.

The first essential in making a diagnosis of Hodgkins disease is to make a satisfactory blood examination. There are two points that constitute a good working basis, (1) the general lymphadenoid hyperplasia, (2) and according to Pinkus an absolute lymphocytosis with a practically normal total white blood cell count.

(1) **Glandular tuberculosis.** It is often extremely difficult to distinguish between lymphadenoma and tubercular adenitis. Should an enlargement of the glands on one side of the neck occur in a young person, it is not at all easy to decide whether the disease is tuberculous or an incipient Hodgkin's. In the neck, tuberculous adenitis is more often in the submaxillary glands, while the anterior and posterior cervical glands are more commonly involved in pseudoleukemia. Tuberculosis is more often a local than a general adenitis. Tuberculous glands have a tendency to coalesce and adhere because of a peri-adenitis, and are more often attended by secondary suppuration. Excision of a gland or glands and histological examination will definitely decide the question. A Morro or Von Pirquet test if negative will assist in excluding tuberculosis. A positive reaction would not necessarily exclude pseudoleukemia because the two conditions co-exist frequently. Tuberculosis does not show the severe form of fever often found in lymphadenoma, unless septic infection occurs.

(2) **Leukemia.** Usually no difficulty is encountered. Microscopic examination of the blood quickly leads to a diagnosis. Rarely does leukemia, (usually the acute lymphatic form), show a gradual decrease in leucocytes, or show a normal leucocyte count for a time. The histological findings in the glands are very different.

(3) **Lymphosarcomatosis.** This condition and pseudoleukemia are often classed together. They are most difficult to differentiate. The glands are usually only locally involved, usually form larger masses, involve the capsules and contiguous structures and ulceration takes place. This never occurs in pseudoleukemia. The easiest and most satisfactory mode of diagnosis is microscopic examination of the gland tissue.

(4) **Anemia Splenica.** It is a question whether this should be considered as an essential anemia or a splenic form of Hodgkin's disease. The spleen is enlarged. There is an anemia of the secondary type—red cells between three and four million, hemoglobin 50% to 75% or lower, and white cells three to four thousand. Hemorrhages are frequent.

Treatment. An open air life as long as the patients physical condition permits, is advisable. Good food in larger amounts than

ordinarily and more frequent to the limit of his digestion. The only drug that has given any satisfaction is arsenic either in Fowler's solution in increasing doses, or in some of the organic preparations of arsenic. Symptoms have disappeared in the course of a few days after an injection of salvarsan.

REPORT OF A CASE.

J. A. N. male, two years and four months of age. A healthy happy child. Ordinary minor diseases of childhood. Took sick about Christmas time last year with a bad cold and an attack of indigestion accompanied with anorexia, vomiting and a high fever. These conditions were very amenable to treatment and the child was very much improved in a few days. During the following six weeks he seemed to be perfectly well except that he was very fretful. This was very noticeable because so contrary to his usual happy disposition. On February the 12th, mother noticed that the boy was breathing very deeply and with considerable exertion and he complained of back, limbs and muscles aching. About a week later mother was first aware of a swelling on the side of the neck. Almost simultaneously baby sustained a paraplegia, edema in both feet, and large subcutaneous hemorrhages on feet and ankles.

Patient first came under my observation on the evening of February the 18th., I found a boy of somewhat anemic appearance but fairly well nourished. Temperature slightly above 100 degrees, groin, pulse 140. Patient perspiring. On examination I found a swelling on the left side of the neck, of the anterior and posterior cervical glands. Each gland was distinct in its outline, movable, and not painful. There were no evidences of inflammation. The glands on the opposite side of the neck were also enlarged but not nearly to the extent of those on the left. Also the axillary glands both sides and inguinal glands were enlarged, as also the gland at the tip of the mastoid process. Thorough examination of the chest revealed nothing. Abdomen was normal, no enlargement of liver or spleen. Edema of feet had almost entirely disappeared. There still remained evidences of the subcutaneous hemorrhages; also numerous spots of erythema. I discovered that the boy was absolutely unable to sustain his weight upon his legs and he seemed unable to control their movement; although while sitting or lying in bed he could draw them up. Patellar reflex was entirely gone in the left leg and very tardy in the right. No Babinski. I found that on two occasions the boy had bleeding from the nose. Once about a dram, again only

slightly. Also that he at intervals had tickling sensations in his limbs.

Blood count was characteristic:

Red corpuscles.....	4,140.00
White corpuscles.....	10,600
Hemoglobin.....	76%

Differential count:

Polymorphonuclear enutrophiles and transitionals.....	56%
Large lymphocytes.....	2%
Small lymphocytes.....	40%
Eosinophiles.....	1%
Myelocytes.....	Occasional
Nucleated reds.....	frequent

I diagnosed pseudoleukemia, put the boy on increasing doses of Fowler's solution beginning with one drop three times a day and increasing one drop daily; and fed him to his limit. He made a slow but good recovery, apparently. The glandular swelling almost entirely disappeared, the reflexes returned, the paraplegia disappeared and he was again able to walk.

During the weeks of the child's sickness his fever never reached a very high point. Occasionally as high as 101 and frequently as low as 97. It would run along very evenly for perhaps a week and suddenly without any apparent reason ascend again a few degrees. The pulse remained constantly between 100 and 130, occasionally reaching 150.

On March 12th the patient was apparently perfectly well and the nurse was discharged. In less than two weeks the boy was dead, death resulting from pneumonia.

—o—

OFFICE TREATMENT OF PELVIC DISEASES.

J. T. SCOTT, M. D., St. John, Kansas.

Read before the Southwest Kansas Medical Society, May 8, 1913.

Office treatment of pelvic diseases at once conveys to the majority of us at least the suggestion of local treatment. It is somewhat strange though nevertheless true that the majority of physicians look upon pelvic diseases as belonging in a separate and distinct class pathologically from diseases in other localities and organs of the body. To say that there is pelvic trouble is equivalent to saying that the treatment must be either local or

surgical. The fact that the general systemic condition may be responsible for the pelvic disorder is perhaps too frequently overlooked.

The administration of any kind of treatment, whether it be local, constitutional or surgical, to be rational, must of necessity be based upon a proper diagnosis. In further elucidation permit me to quote from Dudley the following:

The difficulties of gynecological diagnosis are often increased by the fact that pelvic lesions may exist and cause no definite local symptoms. Even greater confusion may arise from the presence of pelvic symptoms which are caused not by pelvic but by extra-pelvic disorders. The nerve counterfits of pelvic disease are most realistic and bewildering. Nerve strain, or nerve exhaustion, comes largely from the frets, griefs, worries and cares of life. Yet, strangely enough, the most common symptoms of this form of nerve disorder in women are the very ones which lay tradition and dogmatic empiricism attribute to ailments of the womb. They are, in the usual order of their frequency, great weariness and more or less nervousness and wakefulness, inability to walk any distance, and a bearing down feeling; then headache, nape-ache and backache. Next comes scanty, or painful, or delayed, or suppressed menstruation, cold feet, and irritable bladder; general spinal and pelvic soreness and pain in one ovary, usually the left, or in both. The sense of exhaustion is a remarkable one; the woman is always tired, sighs a great deal, shows low spirits and often fancies that she will lose her mind. The skin becomes dry, harsh and scurfy, and pigmentary deposits appear under the eyes, around the nipples, and on the chin and forehead. The symptom group of nervous exhaustion—*anemia*, backache, bearing down, difficult walking, ovarian pain and menstrual disorders—although often without the least gynecological significance, is usually the signal for a gynecological diagnosis. Any pelvic organ showing the slightest irregularity is singled out as the culprit and promptly placed on trial. Endless injurious local treatment and grave surgical operations may now cause the woman to suffer many things from many physicians. If no tangible disorder of the sexual organs is discoverable, the invisible endometrium, or ovaries must take the blame and receive the local treatment. Whatever the inlook or the outlook, a local treatment, more or less severe, is liable to be the issue. Yet these very exacting symptoms may be due wholly to nerve strain, or, what is synonymous, to loss of brain control over the lower nerve centers, and not to direct or to reflex action from some supposed uterine disorder. Neither, for that

matter, may they come from some real, tangible, and visible uterine lesion which positively exists. Thus it happens that a harmless antelexion, a trifling leucorrhoea, a slight displacement of the womb, a small tear in the cervix, an insignificant rent of the perinaeum, or, what is almost always present, an ovarian ache, each plays the part of the will-o'-the-wisp to allure the physician from the bottom factor. To these paltry lesions—because they are visible, palpable and ponderable, and because he has by education and by tradition a uterine bias—he attributes all his patient's troubles; whereas a greater and subtler force, the invisible, impalpable and imponderable nervous system may be the sole delinquent. The sufferer may be a jilted maiden, a bereaved mother, a grieving widow, or a neglected wife, and all her uterine symptoms—yes, every one of them—may be the outcome of her sorrows and not of her local lesions. She is suffering from a sore brain and not from a sore womb.

It is then of the utmost importance that each and every case receive careful study and analysis before beginning any kind of treatment. If there is a constitutional condition which is responsible for the local manifestations then of course treatment should be directed accordingly. If, on the other hand, the local and general manifestations are due mainly to local lesions it is equally evident that successful treatment demands attention to the local conditions. While it is unquestionably true that a goodly number of the so-called pelvic cases require more attention to constitutional and neurasthenic conditions than to local conditions, it is also true, in my judgment, that a trifling leucorrhoea, a slight displacement, a small cervical tear, or an ovarian ache, should receive such attention and treatment as the judgment of the physician dictates. To say that attention to these apparently trifling conditions does not usually result in permanently relieving the patient, is not a sufficient reason for abandoning all forms of local treatment. The same statement applies with equal force to constitutional means and remedies. Rather would it not be better to take the more reasonable ground of administering both general and local treatment according to the indications in each individual case.

Surgical measures are not to be considered in a paper on office treatment of pelvic disease, unless they be of the simplest character, such for instance as the drainage of an easily accessible pus sac, the use of the dull curette, the removal of polypi, small growths, and such other simple surgical procedures as can be successfully performed by the aid of local anesthesia.

As was said in the beginning of this paper, office treatment of pelvic diseases conveys the suggestion of local treatment, the principal procedures of which are first the hot water vaginal douche, second tamponade, third, topical applications, and fourth, electricity. The use of the hot water vaginal douche is a time honored custom which physicians generally recommend. It has a wide field of usefulness when properly administered. Your familiarity with this simple and effective remedy renders a detailed description of it's use unnecessary. It is sufficient to say that it acts as a vaso-motor stimulant and as a cleansing agent. It relieves congestion, promotes absorption of morbid products and improves local nutrition. It is, however, an inconvenient method of treatment to administer in the physicians' office, hence the usual custom is to recommend it's use at the patient's home. To get beneficial results it is necessary that explicit directions be given the patient or attendant covering every detail in the procedure. When other methods of local treatment are to be administered it is usually wise to direct the use of the hot douche before the patient comes to the office.

The tampon is used when there is inflammation or hemorrhage. In inflamed conditions it serves a three-fold purpose as follows: pressure effects, vehicle for medicinal applications and drainage. It may be used successfully in controlling hemorrhage from the vaginal surfaces and in cases of intra-uterine hemorrhage it is most satisfactory, the uterine cavity being filled through a packer with narrow aseptic or preferably adrenalin gauze. It should be remembered that tampons quickly become foul from retained discharges, hence, they should not be allowed to remain in situ more than twenty-four to forty-eight hours. Lambs' wool is superior to absorbent cotton where pressure effects are desired. For other purposes the aseptic or medicated gauze strips are to my mind preferable.

Topical applications find their main field of usefulness in the treatment of inflammatory conditions of the vulva and vagina, including the vaginal portion of the uterus. Local applications of the remedies indicated should be here used in the same manner that they would be used under like conditions in other parts of the body. Vulvitis, vulvo-vaginitis, vaginitis, cervical endometritis, eczema vulvæ, herpes vulvæ, pruritis vulvæ, vaginismus, etc., are conditions that respond favorably to proper topical applications. Intra-uterine medication however, is not so simple or satisfactory. My experience in the use of topical applications to the uterine cavity has been such as to create within me a very considerable

respect for the sanctity of that cavity. I recall vividly that in more than one instance I have been surprised at the severe symptoms following the introduction of a simple sound into the uterine cavity. It is no doubt true; that uteri differ greatly as to sensibility, but that the vast majority of them resent invasion beyond the internal os, by any kind of a foreign body, is equally true. In inflammatory conditions of the endometrium intra-uterine medication is a time honored custom of very questionable virtue. I am constrained to the opinion, both from practical experience and from the careless manner in which such medication is used, that it is the psychic, rather than the medicinal effect, upon which the physician bases his hopes for improvement. And it may be truthfully added that such a basis for hope is sometimes worthy of consideration. It should be remembered that mild applications can accomplish no good in a condition of such severity as to call for intra-uterine medication, and that the use of strong, topical applications is fraught with great danger. If it is decided that such treatment should be administered unusual precautions are necessary in order to insure against the introduction of additional septic matter. The vulva and vagina should be rendered as nearly aseptic as possible; the cervix sufficiently dilated, and the medicinal agent thoroughly but gently applied to the uterine surface by means of sterile cotton wrapped on the end of a uterine sound or dressing forceps. Good results sometimes follow this method of treatment and especially so when used subsequent to curettage and some other intra-uterine surgical procedures.

My own personal experience does not justify me in making more than mention of the use of electricity in pelvic diseases. In reviewing the subject I am positively non-plussed at the irreconcilable opinions regarding it's virtues and it's uses. On the one hand leading gynecologists, in fact, recognized authorities state that after sufficiently long continued use they have become convinced not only of it's failure to fulfill the promises made for it, but that it is apt to be harmful and dangerous; while on the other hand, equally noted authorities give it a place above all other therapeutic agents or methods of treatment, not even excluding surgery. That it is a therapeutic agent of great value in properly selected cases I do not doubt. It's successful use, however, demands a thorough knowledge of the scientific principles involved and patient attention to detail. It is stimulant or sedative, constructive or destructive according to the modality used, when used cataphorically a destroyer of pathogenic germs and septic material. It is also a diagnostic agent of unusual

worth. The galvanic, faradic, static, sinusoidal and high frequency currents with their various modifications are all adapted to the office treatment of pelvic diseases. In certain conditions and for certain purposes it is a remedy without a peer, but when used unintelligently it is capable of much harm. The same, however, may be said of any potent remedy.

In conclusion I desire to call attention briefly to uterine displacements. Every practitioner who essays to treat pelvic diseases locally is, early in his experience, struck by the number of women who come to him believing that they are suffering from falling of the womb. It may be a prolapsus, it may be a version, it may be a flexion, or it may be some other pathologic pelvic condition, but to the patient it is almost invariably falling of the womb. To some of them no hope can be offered save through surgical interference, but to a large number, local treatment properly applied will bring relief even to the extent of symptomatic cure. The agencies, combined or alone, are the hot douche, the medicated or non-medicated tamponade, the pessary and the electric current.

Mention has already been made of all save the pessary. I am aware that a goodly number of physicians absolutely condemn the use of any and all kinds of pessaries, claiming that they are not only useless but harmful. I am convinced that such statements are not only unjust but untrue. From personal experience I am prepared to say that I have seen many cases where the use of a properly adjusted pessary has given great relief. They are perhaps more helpful in retroverted conditions. Their unqualified condemnation is in my opinion due to attempted use in unsuitable cases. There are a number of different kinds of pessaries, each intended to relieve some special condition. The hard rubber antiversion and retroversion, the soft rubber, the stem, etc. A properly adjusted pessary occasions no discomfort, in fact the patient is not conscious of its presence after it is introduced. Pain or discomfort is *prima facie* evidence that something is wrong and any pessary that produces it should be removed. When properly adjusted they may be left in situ indefinitely but for various manifest reasons should be removed and properly cleansed as often as twice a month. It may be well to remember that the hard rubber pessary should not be immersed in hot water for cleansing purposes as it will lose its shape.

THE RELATION OF THE PUERPERIUM TO THE PRESENT AND FUTURE HEALTH OF WOMAN.

DR. W. C. BUNDRANT, Partridge, Kansas.

Read before the Reno County Medical Society, December 22, 1912.

"The seed of the woman shall bruise the serpent's head" and the care we give her during the puerperium determines the fate of our nation for good or bad. The gynecologists' waiting rooms are filled to over-flowing with mothers for treatment, and who date their troubles to child-birth and truly in my mind the most of the trouble is due to improper care during the puerperium.

The puerperium is from the completion of the third stage of labor to the complete involution of the uterus, which is usually about six weeks. The non-pregnant normal uterus is $3\frac{1}{2} \times 2\frac{1}{2}$ in, $\times 1\frac{1}{2}$ in, and weighs $1\frac{1}{2}$ oz. to 2 oz. Just think of a puerperal woman getting out, up and stirring around doing her household duties on the fourth or sixth day following child-birth, when the uterus is yet large and heavy. Immediately after birth and delivery of the secundines of full term pregnancy the uterus is as large as the pregnant uterus at the twentieth week and will weigh 26 to 35 oz. At the eighth day of the puerperium the size of the uterus should be reduced to one half of the 26 to 35 oz., which is 13 to $17\frac{1}{2}$ oz., compare this to the non-pregnant normal uterus $1\frac{1}{2}$ to 2 oz. It is said that the old Indian squaw would step out of the line of march and give birth in the grass or leaves and immediately resume the march. We all appreciate the saying, "We grow wiser and weaker". And too, you have heard of woman being compared to dumb brutes in birth and the care following it. Some "old granny" woman looms up and says, "It is natural for woman to have babies and why have such a big thing over the care of her at this time?" If the woman could walk on her allfores like a brute, that heavy uterus would not be so likely to get off its equipois. The mother who gets up to do her daily tasks shortly after birth burdens herself in the future in some way. She may cause subinvolution, flexion, version or prolapse and these in turn will produce most any ill condition a woman is heir to, on anything from simple headache to extreme neurasthenia.

The puerperal woman should not get out of bed and try to resume her household duties under three weeks or 21 days. She, by rights, ought not to do any undue lifting for six weeks following labor. The woman should place herself in the knee-chest position four or five times each day after getting up out of the lying-in bed

for five or ten minutes each time until the puerperium is well to a close. Heavy lifting causes contraction of the abdominal muscles and hence greater intra-abdominal pressure pressing down on the heavy uterus causing displacements and disturbed normal circulation in the reproductive organs.

The attending physician should see the mother more often than is common after delivery—and he gets his fat fee. Of course, the profession is to blame a great deal for the objection the laity has to calling the doctor to make these following visits. The laity think it is to make a big bill, if you merely say it is advisable to see the mother a number of times in the puerperium. We should instruct them and hold them long enough to convince them of the necessity and importance of the proper care of the mother following child-birth. We tell the laity too little about themselves, especially child-birth and the puerperium.

It is said that a certain man was once asked how we must do to really become great and he said, "Commence on the child's great-grandmother." Intelligence must be supported by a good physical body before it can manifest itself greatly, hence, it is a prime important thing that we take better care of the mother in the puerperium, if we are to expect more normal statures and physical bodies.

Perineorrhaphy and trachelorrhaphy should be considered here as in many cases a torn and lacerated perineum or cervix can be repaired with more ease when recent than when late. You do not have to, as a rule, do any trimming or cutting when it is a recent laceration, for this and other reasons we should repair now than later, and especially the perineum. Some physicians repair the cervix immediately but in my mind this is questionable whether or not it should be done immediately. I had rather think that cervical repairs can be done with more satisfaction at a later date.

But, "a stitch in time saves nine," is well said; and to do these repairs and especially the perineum immediately while the edges are fresh, provided there is no contraindication, precludes a mountain of trouble for the patient. We do not think and speak forcibly enough on this one thing. We all know what perineal and cervical lacerations unrepaired lead to and no doubt, in my mind that one of my best friends would be living now, had she been cared for properly in her puerperium. She died at the age of 54 of cancer of the uterus due to unrepaired cervical laceration. If the patient has a cervical laceration it should at least be known before the six weeks are gone and tell the patients husband about it

and keep an eye on the condition that it may be repaired in due time.

At I stated in the outset, the relation of the puerperium to the present and future health of woman, and to treat this subject properly we must be connected to the labor even and if it is a good puerperium we would at least expect favorable conditions prior to the puerperium. If it is a normal birth and the puerperium seems normal, it cannot be too often repeated that perfect cleanliness and absolute physical and mental rest should usher in the puerperium. The external genitals should be kept clean and antiseptic. This is best done by washing with sublimate 1:4000 or lysol solution (2%) and paying special attention to the flexures of the thighs or any folds or creases of the skin. The lips of the vulva need not be separated while washing. Too many of us forget that fact that Nature is the best doctor. If there has not been introduced some harmful bacteria at labor the birth tract remains cleaner of itself than we can make it. If some of the membranes are left Nature will take care of the condition more often than it will fail, if non-infected. Doderlein has distinguished microscopically two secretions of the vagina; one, the normal secretion, a whiteish, milky, strongly acid discharge without mucus admixture; the other a pathological secretion, yellowish, faintly acid, often neutral or alkaline, sometimes foamy and mixed with mucus. In the normal secretion a non-pathogenic vaginal bacillus was found constantly present, hence, if we try to be clean we must have a clear-cut reason for every thing we do or else we destroy Nature's provisions. Vaginal douches must not be given unless we know what we are doing. We may destroy our very best friends. Let the woman rest, if she has a harmless flora in her vagina, and if she has had proper care during labor she is not likely to have pathogenic bacteria in her vagina. I do not douche the vagina in the puerperium unless there is special indications of pathogenic bacteria being present. There should be vulval dressings and there are three essentials of a vulval dressing; it should be of absorbant material, it should be saturated with an antiseptic material that the discharge may be sterilized; and should be impermeable that the air may be excluded. The proper fitting abdominal binder may or may not be used as the case demands. If it is a loose flabby multipara the binder is much more needed than the close built primipara who has had normal labor. We all know that there are just as many good men against the use of the binder as they are for it. Of course sound judgment should supplement all quibbling in each individual case.

Physicians of the present day have, as a rule, but a faint conception of the importance of puerperal fever in the history of Nineteenth Century Medicine. Pepper, in his *System of Medicine* (1885) devotes 44 pages to discussion of this disease, and gives an interesting series of statistics showing that from 1868 to 1875 inclusive, out of 3342 deaths due to diseases complicated in pregnancy, etc., 1947 were due to inflammatory processes which had their starting point in the generative apparatus.

The puerperal fever commission, appointed by the Berlin Society Gynecology and Obstetrics, reported that this disease destroyed nearly as many lives as smallpox or cholera. The origin and nature of this disease was misunderstood and made the subject of much discussion and dispute. In 1860, Summerweis published the first true conception of the nature of this disease, but died with no other reward than the scorn of his contemporaries.

In the year 1871, the mortality from child-bed in New York was 399. In 1872, 503; 1873, 431; 1874, 439; 1875, 420.

In an essay published in 1843 by Oliver Wendell Holmes, the testimony in favor of contagion was presented in a complete and conclusive form, which has exercised the most beneficial influence upon the practice of midwifery in America.

Lusk, states, "with his many claims to our admiration and esteem there is probably no title that Professor Holmes wears with greater pride than that of pioneer in a movement that has done so much to prevent the slaughter of innocent women and the wrecking of happy homes."

It remained for Garrigues to practically and clinically demonstrate the truth of Holmes' theories and the remedy for the condition.

In the winter of 1883-4, partly because of the dreadful conditions prevailing at the New York Maternity, the subject of puerperal fever was prominently before the profession. In the first nine month of '83 with 345 deliveries, 30 women died. In September conditions were at their worst. October 1st, brought Dr. Garrigues in charge. His plans was original in its details, showed a broad comprehension of the principles of asepsis, was brilliant in its achievements and of far reaching influence upon the practice of obstetrics. The lesson was taught the world and the world has heeded it well.

"Garrigues, the man who saved and taught us how to save the mothers of men, lives to know that we know the value of his deed, lives to know the place of honor he holds in the hearts of his fellows, lives in the pulsing blood of happy wives and mothers, and has an immortality in thousands yet unborn."

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,

-

-

-

-

EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

This month's Journal contains very little news, especially of medical meetings about the state. Meetings are undoubtedly being held as frequently as in the past, but the Journal has NO WORD OF THEM.

—o—

The fight of the antivivisection society has again been renewed, the attacks now being centered on some prominent members of the faculty of the University of Pennsylvania, who have been arrested on charges preferred by "the society" for alleged cruelty to animals. These attacks are simply the result of fanatics having their periodical attacks of dementia and their misguided efforts must not and will not curtail animal experimentation from which, such valuable discoveries have arisen.

—o—

We are happy to announce that Dr. S. J. Crumbine, secretary of the state Board of Health, who was recently successfully operated upon for duodenal ulcer by Dr. Crile of Cleveland, has left the hospital and will return to his duties next month. He is now recuperating at a summer resort in Wisconsin. During his absence Dr. J. J. Sippy has charge of the Board of Health.

EDITORIAL CLIPPINGS.

Chiropractic—A Judge's Opinion—Chiropractic is a freak offshoot from osteopathy. Disease, say the chiropractors, is due to pressure on the spinal nerves; ergo, it can be cured by "adjusting" the spinal column. It is the sheerest quackery, and those who profess to teach it make their appeal to the cupidity of the ignorant. Its practice is in no sense a profession but a trade—and a trade that is potent for great harm. It is carried on almost exclusively by those of no education, ignorant of anatomy, ignorant even of the fundamental sciences on which the treatment of disease depends. A chiropractor of Canton, Ohio, was recently fined \$200 and costs and sentenced to sixty days in the workhouse for practicing medicine without a license. In imposing sentence, Judge Krichbaum, before whom the case was tried, said in part:

"There is unfortunately growing up in this country of ours a general defiance of the law. In the opinion of the court, you and the school to which you belong are in this class. This court does not take much stock in the claims you make that you were not practicing medicine. It is not within the province, nor the purpose of the court to criticize the class of school to which you belong, nor the efficiency of your treatment. . . . You claim to be a doctor of chiropractic; the technical meaning of the word 'doctor' is a person, learned, well-taught, well-informed, and universally a doctor is recognized as being able to alleviate physical suffering. For a long time there has been running in the magazines an advertisement: 'Be a Doctor of Chiropractic, the new Drugless Healing Science of Spinal Adjustment; a common school education is all you need to begin; our simplified training does the rest.' Men who believe in education, who glory in our school system, in our colleges, are staggered at this audaciousness. Certainly to conform to the requirements in the practice of medicine in the State of Ohio, could only make you more efficient, more capable for the practice of your profession. . . . The logical results of permitting you to practice medicine without a certificate from the state board would be to lower the standards of school-teachers, of druggists, of physicians and every other class necessary to maintain an orderly regime of civilization, and wholesome living—in short, to open the doors for all charlatans to prey on the suffering. There is a growing tendency to raise all intellectual standards. The execution of this law rigorously will be a step in this direction."

Canton is to be congratulated on having a jurist with as broad

a grasp of fundamentals as that shown by Judge Krichbaum.—
Journal A. M. A.

—C—

Danger in Tonic Summer Drinks—In addition to the drinks containing dangerous chemical flavoring and coloring substances, there are other "temperance" drinks equally dangerous, especially for the children and young persons who indulge in them so freely. Many of the rather misnamed "tonic" drinks that are so widely advertised have been shown by the United States government analysis to contain considerable proportions of caffeine. It is easy to understand that after taking these caffeine containing-cold drinks the feeling of fatigue may drop from one. Caffeine is not, however, a desirable stimulant to serve indiscriminately to growing children or young adults, especially those city dwellers whose nervous systems certainly need no artificial stimulation. Besides, caffeine seems to have a definite tendency to the formation of a habit. Not a little of the restlessness of children during the summer is to be attributed to the taking of caffeine in considerable quantities in the form of these soda-fountain drinks. The parents sometimes discover that a distinct craving for the particular drink has been created and that the child pleads for money to satisfy that craving. After reading the advertisements of the marvelous tonic and stimulating virtues and fatigue-dissipating qualities of these preparations, the parents feel sure that there cannot be any harm in such well-recommended beverages, especially since they are sold in a favorite drug-store. Unfortunately, says The Journal of the American Medical Association, this confidence is not justified; it is necessary to draw a sharp line between bottled tonics or drinks containing caffeine and the relatively harmless carbonated soda-water of the soda-fountain, when served plain or with wholesome flavoring matter.

—O—

SOCIETY NOTES.

Program of the Harvey County Medical Society for August:

"TYPHOID FEVER."

"Diagnosis," Dr. J. L. Grove.

"Treatment," Dr. F. L. Abbey.

"Pathology," Dr. R. H. Hertzler.

Review of Recent Literature or Report of Case, Dr. Max Miller.

F. L. ABBEY, Secretary.

The Wyandotte County Medical Society will open its fall session October 7th. This society has more than 100 paid up members.

—O—

The Northeast Kansas Medical Society will meet at Leavenworth, September 25th. The secretary, Dr. C. C. Goddard is now preparing the program which will appear in the September issue.

—O—

The Medical Association of the Southwest will hold its annual meeting at Kansas City, Mo., October 7th and 8th.

The committee in charge of the special clinics promise a week full of interesting things, beginning at 8 o'clock Monday morning, October 6th, then again on Thursday morning and lasting until Saturday evening. These clinics alone will be worth the time and expense of going to Kansas City.

Dr. J. A. Witherspoon, President of the A. M. A., has accepted an invitation to be present, and will deliver an address Tuesday evening.

Dr. F. H. Clark, of El Reno, Oklahoma, is secretary.

—O—

NEWS NOTES

Dr. Guy Aplin Finney, who recently completed an internship in the University of Kansas Hospital at Rosedale, was married July 23rd to Miss Bertha McMillan of Wamego.

—O—

The XVIIth International Congress of Medicine meets in London this month. Dr. Clifford P. Johnson of Coffeyville and Dr. Elwood Armstrong of Greenleaf, left New York July 3rd to attend. En route a program of papers were to be presented, Dr. Johnson reading one on "Diseased Tonsils and Their Treatment."

—O—

NORTON GETS THE SANITARIUM.

Committee Selects Site for Kansas State Tubercular Farm.

Topeka, July 28—The Kansas Tubercular Sanitarium will be located near Norton, Kansas. The committee of physicians appointed to pick the site made the recommendation to the board of control today. The place is three miles east of Norton. Under the law appropriating \$49,500 for the sanitarium and its operation it was provided that 160 acres must be given the state.

Only one large building will be erected, the administration

office and residence of the superintendent. The other buildings will be small cottages of the "lean-to" type with big verandas. The state will farm enough of the land to provide all the feed necessary for the dairy herd and poultry farm, the chief items of diet for the tubercular patients.

—o—

OBITUARY.

Elza Van Coldren, M. D., College of Physicians and Surgeons, Keokuk, Iowa, 1864; a fellow of the American Medical Association; a veteran of the Civil War; for more than thirty years a practitioner of Topeka, Kans; died at the home of his daughter in that city, July 17, from senile debility, aged 72.

—o—

James A. Rea, M. D., College of Physicians and Surgeons, Keokuk, Iowa, 1875; Barnes Medical College, St. Louis, 1899; a member of the Kansas Medical Society; formerly a member of the American Medical Association; died at his home in Wellington, June 28, from nephritis, aged 72.

—o—

Solomon T. Metty (license, Kansas, 1901); for more than half a century a practitioner of Topeka; died at his home June 30, aged 76.

—o—

Communications.

AMERICAN MEDICAL ASSOCIATION COMMITTEE FOR PUBLIC HEALTH EDUCATION AMONG WOMEN.

June 27, 1913.

Chas. S. Huffman, M. D., Columbus, Kansas.

Dear Dr. Huffman—We have come to the close of another year of the work of this committee, in which we find that workers throughout the United States have about doubled that which was done last year. The committee is organized in forty-five states and 455 counties, 410 of which have been active during the last year.

The form of organization which we are seeking to develop is for the State Medical Society to appoint a committee for Public Health Education, one member of which shall be State Chairman under the American Medical Association Committee. This state Chairman together with the committee appointed by the State Association shall work together to secure the appointment of committees for Public Health Education in the county societies, one member of such committee to be county chairman under the American Medical Association Committee. In this way the committee

under the State Society can coordinate the work done within the state and the American Medical Association Committee can coordinate the work done in the several states. The work in each state will be under the direct supervision of the State Society and at the same time may have the advantage of experience in other states.

At the present time many state societies are appointing committees, and in other states physicians are much interested in the education of the laity. We hope that you will be interested in organization of public health work.

Dr. Emma L. Hill will be chairman for your state, under the American Medical Association Committee during the coming year. We believe that she will work with your State Committee if you have one, or will be interested in trying to secure such a committee at the earliest possible date.

After July 1st, Dr. Lenna L. Meanes and Dr. Martha Welpton of Des Moines, Iowa, will serve on the Central Committee as Chairman and Secretary, respectively. They are cordially endorsed by the profession of their own state. From our knowledge of the men and women interested in public education, we are assured of the future.

Very cordially yours,

ELENOR S. EVERHARD, Chairman.

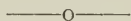
GERTRUDE FELKER, Secretary.

—o—

REVIEWS.

Inguinal Hernia—U. C. Bates, Seattle, Wash. (Journal A. M. A., June 28), describes a new method of operating for indirect inguinal hernia. An incision about two inches long is made parallel with Poupart's ligament, its end about an inch above the usual location of the internal ring. The fascia of the external oblique is divided in the line with its fibers. The arching fibers of the internal oblique are separated and retracted, and the fascia of the transversalis together with the peritoneum is opened. Any adhesions can be broken up by traction and blunt dissection with the finger. "The internal ring, including the neck of the sac, is caught up with an Allison tissue-forceps or a hemostat and pulled up to the incision, where a purse-string suture of No. 3. plain catgut, on a needle, is passed around the circumference of the ring, engaging the fascia of the transversalis except at the junction of the inner and lower quadrant, where the vas deferens or round ligament is encountered; this is excluded externally from the ligature. Pulling up the internal ring and transversalis fascia

restores them to the original position held before a hernia was produced. The purse-string is drawn taut, tied, and the same suture is passed from within through the parietal peritoneum and through some of the fibers of the internal oblique muscle. It is then passed from without inward through the muscle and peritoneum of the opposite side of the incision, where it is tied to the free end of the purse-string. The next stitch is then passed through the peritoneum then through what is now the superior portion of the ring. When this is drawn tight it faces and holds the ring firmly against the parietal peritoneum. The remainder of the peritoneal incision is closed by a continuous stitch with the same suture. The remainder of the wound is then closed in the usual manner." The operation has been performed in six cases since October, 1912, and in no case has there been a recurrence. The advantages claimed are its simplicity, the smaller incision required, the restoring the inguinal canal in an oblique direction by drawing the internal ring to its normal position and so directing the intra-abdominal pressure as to render the recurrence of rupture impossible. There is also a better chance for making resection, if necessary, in case of strangulation, and little or no shock or pain following the operation. The article is illustrated.

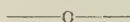


Skin Cancer.—F. H. Williams, Boston, and F. W. Ellsworth, Quincy, Mass. (Journal A. M. A., May 31), give their results in tabulated form with the direct radium treatment of skin cancer and report a certain number of cases grouped together according to their conditions and especial methods of treatment and their results. They say that the tables and illustrative cases demonstrate the efficiency of a proper quantity of pure radium bromid in superficial skin cancers, especially in the earlier stages, both as to healing and permanency of result. This is true in cases in which it alone was employed, but its usefulness was also shown when used in recurrences after operation or other treatment. As a rule, they employed 50 mg. of pure radium bromid, using screens or filters of aluminum of varying thickness when it was desirable to absorb some of the less penetrating rays. Not over two applications a week should be made, and the duration may vary from one to two for ten minutes, according to the extent and depth of the disease, all parts being exposed to the radium. In later and extensive cases, even half an hour is used in the application. Now and then two or three applications are sufficient, but more frequently 10 to 15 or more are necessary. Lengthening of the treatment might reduce the number, but the authors preferred to use

not too vigorous methods and keep within safe limits. Definite rules as to number and duration of sittings cannot be stated. Experience and judgment are the best guides. When the lymph-nodes are involved no time should be lost by using radium on the outside. They have not had permanent results from treating new growths in the mouth; the patients usually delayed too long. Their conclusions are given as follows: "1. The application of pure radium bromid in sufficient amount, properly used, is a harmless, painless and efficient method of treating early superficial new growths. Radium is well adapted to cancers of the face, as the cosmetic results are excellent, and particularly to the eyelids, where operation may offer special difficulties and disadvantages. With proper care there is no danger to the eye. 2. Operation is still considered the method of choice in early skin cancers by most practitioners, but the results obtained here and abroad show, we believe, that radium should be used first in early cases and operation reserved for those that are not controlled by it. 3. Radium is more successful when it is the first treatment employed than when it is used after operation, x-rays or other forms of treatment, although even under these circumstances it does well. 4. The number of treatments required in some cases is from two or three to ten, while in others more than twenty are needed. Improvement usually takes place after two or three applications of the radium. 5. Many people dread the knife, even for a simple operation and fearing surgical interference will be advised, delay coming for treatment, thus lessening the chances of recovery; but radium is free from dread, as its action is painless. 6. The analgesic action of radium is noteworthy. 7. For keloids, unless extensive, radium is by far the best treatment known to us. 8. All powerful remedies have dangers, but they can be avoided if care is taken. During the seventeen years the x-rays have been used at the Boston City Hospital no patient has been burned, nor have any untoward results occurred in about ten years during which radium has been employed there."

Carbuncles and Boils Treated by Large Doses of Dilute Sulphuric Acid—J. Reynolds and R. J. Reynolds (The Lancet, Mar. 15, 1913) "report favorable results obtained by administering internally dilute sulphuric acid B. P. in 20 or 30 minim doses, each dose diluted with 2 ounces of water, every four hours. In the case of carbuncle treated by this drug in large doses (small doses are not of the slightest use), changes are observed to take place in the following order: First, within twenty-four hours the in-

filtrated area of tissue becomes strictly circumscribed; then the slough is observed to soften; during the next few days pus is freely discharged, and the whole affected area shrinks and healthy granulation tissue forms, filling up the cavity until the part is healed. The cicatrization takes place in a comparatively short time from the commencement of the treatment, the period varying, of course, with the size of the lesion. The only external application is a dressing of carbolized vaseline (1 in 20). Naturally in cases of what would appear to be streptococci infection, such as those resulting from abrasions, or punctures by bones of high game, or inoculation by decomposing animal matter, the patient showing early symptoms of septicemia, a somewhat different though favorable course obtains; the high temperature is quickly reduced and the pain and swelling and malaise gradually subside, the patient progressing uninterruptedly towards convalescence. Where the lymphatics are inflamed and the glands enlarged and painful these conditions in a few days also disappear."—Medical Record.



Roentgen Treatment of Carcinoma of the Uterus, Breast and Ovaries—Since 1911 Professor G. Klein (Munch.med. Wochensch., No. 17, 1913), with the assistance of Drs. Hirsch and Monheim, has tried the Roentgen treatment of uterine cancer with a new and improved apparatus in twenty-one cases. In twelve of these cases the procedure was resorted to after hysterectomy and in nine for inoperable uterine cancer. Besides these, one case of mammary and five of ovarian cancer were treated by this method. In every instance the favorable influence of the rays upon ovarian carcinoma was unmistakable as shown by the slower growth and firmer consistence of the tumor. Among the cases of uterine cancer three were considered particularly noteworthy. The first was one of cancer of the cervix, extirpated by Wertheim's method, in which the x-rays were used for the treatment of recurrences in connection with curettage, with prevention of any further return of the disease. In the second case, a malignant adenoma of the cervix, in which the pelvis was filled with the growth, the cancerous mass was converted into a tumor with thick connective tissue walls occupying a much smaller area. In the third case radical operation had been done for cancer of the cervix. An infiltration was left on one side which subsided completely after the use of the rays. Klein urges immediate resort to Roentgen treatment as a prophylactic after radical operation for uterine cancer, for the purpose

of destroying any microscopic remnants of the disease. In inoperable cases he advised curettage and cauterization, followed by the use of the x-rays. He also refers to a case of cancer of the breast, in which after amputation nodules recurred which were repeatedly extirpated, the x-rays being used during the intervals. After extirpation of the last nodule, which shown to have no cancerous elements, no recurrence has taken place within two years. Similar results have been published by others.—International Journal of Surgery.

—o—

Hydrogen Peroxid—P. G. Heinemann, Chicago (Journal A. M. A., May 24), describes his investigation, its methods and results, of commercial preparations of hydrogen peroxid. He finds it has considerable value as a germicide in its power of reducing the number of bacteria and the harmlessness of the decomposition products. It cannot, however, be depended on for complete destruction of even such sensitive bacteria as *B. typhosus*, *coli*, or *B. prodigiosus* in water or milk. Commercial preparations of hydrogen peroxid often vary in composition, depending on the age of the preparation, the temperature at which it has been kept and on the presence of foreign substances. They are not, therefore, to be depended on unless the composition at the time of use is known. Magnesium dioxid tablets, though probably more stable than solutions of hydrogen peroxid, are not soluble and must be pulverized adding to the substance to be treated, and even then the evolution of hydrogen peroxid seems to be gradual and irregular. The temperature at which the action is to take place must be high enough to insure germicidal activity. Ordinary room temperature is to be preferred and milk and water should be cooled after the period of action to make them palatable and prevent multiplication of the remaining bacteria. Heinemann concludes as follows: "For practical application in rendering water and milk safe, hydrogen peroxid solutions can at best be considered only emergency measures. Expense, uncertainty of composition and its possible influence on organic constituents and enzymes are complicating factors. The use of hydrogen peroxid solutions can be recommended only if pure solutions are available, but this procedure can never take the place of efficient water infiltration or efficient pasteurization of milk."

MISCELLANEOUS.

Necessity of Vital Statistics—The earnest, intelligent health officers relies on statistics for an understanding of his field. A

tax-collector cannot discharge his duties unless he knows the address of every debtor. A police bureau cannot protect society unless it knows the character and haunts of the degenerates. A health officer cannot execute the law for the protection of society's health unless he knows the haunts and habits of disease. For this he must look to vital statistics.—Dr. William H. Allen.

Complete Loss of Hair Caused by a Psychic Trauma—An interesting case of trophic disturbance after a fright was demonstrated recently at the Gesellschaft der Aerzte by Docent Dr. Nobl. A tram-car driver, otherwise healthy, 31 years of age, had a collision with an automobile. Seeing the auto dashing toward his tram, he made the utmost attempts to stop the inevitable crash, and jumped off the platform just in the nick of time. He was speechless for some minutes after the accident, otherwise unhurt, but fearfully upset and out of his wits. A few days afterward he noticed that his hair on the scalp came out in handfuls, his mustache and beard could be pulled out, and his eyebrows as well as all other hair on his body fell out in the course of the next four weeks. Only a few single hairs remained in the right armpit and on the pubes. At the time of demonstration, the skin was completely free from hair, smooth and glossy, no other pathologic condition being visible. The explanation given for this neurotic alopecia is that from the central functional (emotional) irritation, vasomotoric impulses were given off to the small arterioles of the skin. This temporary disturbance of the skin circulation, as shown by a contraction of the smaller arteries, is sufficient to interfere with the continuity of the matrix cells of the hair, and thus prepares the loosening of the hair from its follicle.—Vienna Letter—Journal A. M. A.

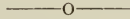
A Hom'let Come to Judgment—A physician who was so well acquainted with the editor of a medical journal that he felt free to express his mind, ended up the discussion over the rejected article by saying with some heat:

"Well, Phil, I suppose I am foolish to try to get you to appreciate the merits of this article; you never wrote an article yourself, so you do not know anything about it."

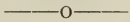
"No", retorted Phil, "and I never laid an egg, but I am a better judge of an omelet than any hen in the state."—Doctors' Factotum.

LOYAL.

Sister Kittie's home from college with a host
 of modern kinks
 In the way of hygienics, sanitation, food, and
 drinks.
 Proteids and carbohydrates she combines
 exactly right.
 For the strictly balanced ration she identi-
 fies at sight.
 She knows all about digestion, what is best
 for us to eat,
 What we need for body-building, growth
 and force, repair and heat;
 And the dinner-table's lovely when my sis-
 ter has it set;
 But we haven't lost our confidence in Moth-
 er's cooking yet! —March Lippincotts.



Public Health against Private Gain—The food adulterators and the "patent-medicine" fakers are the real foes of the national department of health. They skulk in the background behind vapid legislators who prate of state rights, behind complaisant officials willing to support silly charges against upright administrators, behind honest Christian Scientists, misled as to the real purpose of the proposal, behind anti-vivisectionists and anti-vaccinationists and all the fanatics they can rally to their support with talk of medical freedom. The medical freedom they seek is freedom to poison, debauch and slay, and their opposition should bring to the support of the movement every decent citizen.—Pearsons' Magazine.



An Important Decision in Relation to the Discretion of a Surgeon in Performing an Operation—Justice Garrison of New Jersey Supreme Court, who was himself a prominent member of the medical profession, rendered at Trenton, on July 14, an opinion in which he holds that a competent surgeon has the right to extend an operation beyond the limits originally contemplated without permission from the patient when in his judgment such extension is necessary, and the patient is under an anesthetic. The case in which the decision was given was that of Bennan versus Parsonnet, in which

the plaintiff sued Dr. Victor Parsonnet, of Newark, for assault and battery and recovered in a lower court a verdict of \$1,000 damages because the surgeon performed a more extensive operation than the one agreed upon. Bennan applied for an operation (the nature of which is not stated) which two years before had been unsuccessful and Dr. Parsonnet, learning that he was a poor man, agreed to operate free. During the performance of the operation it was found that the condition was more serious than had been supposed, and that unless an extension of the procedure was made at once the patient would probably die. Accordingly, this was done, and the man recovered from the operation and is now well. The suit which he brought is certainly a remarkable expression of his gratitude for this happy result. Justice Garrison, while upholding the common law principle that a surgeon, must get the consent of a patient before operating, grants that the unconscious condition of the patient would prevent this. The common law must therefore give way before the exigencies of the case, and the patient must abide by the judgment of the surgeon.—The Boston Medical and Surgical Journal.

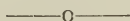
—C—

Advertismo Occulta—A Recent Disease—Advertismo occulta is not yet described in text-books, though numerous sporadic examples have occurred within a year. Students of mental diseases would describe it as a form of "exhibitionism." It is an affection of the sense of justice. Recently a well-known surgeon came down with it. A review of the reported cases seems to show that this disease particularly affects surgeons. In brief, advertismo occulta is that form of advertising in the lay press or magazines, of which the subject (hero) is not supposed to be aware that he is being described.—B. Joseph in Vermont Medical Monthly.

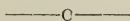
—O—

First Recorded Caesarean Section in America—John L. Richmond, who made the first Caesarean section in America, was the subject of a valuable historical and illustrated lecture by Dr. Otto Juettner before the McDowell Medical Society of Cincinnati, at the January meeting. Richmonds' case was reported in Drake's Western Journal of Medical and Physical Sciences, Vol. iii, 1830,

p. 435, which Dr. Juettner quotes in extenso in his paper. Richmond was a Baptist minister and by acting as janitor at the Medical College of Ohio was able to graduate in medicine in the first class in 1822. The operation mentioned was done on the night of April 22, 1827, in a log hut hastily prepared for temporary habitation. The only light was a flickering candle and the only assistant, a woman, had to spend most of her time holding a blanket about this frail light to prevent the raging storm from without putting it out. The child was dead when removed. The mother recovered. Three years ago the McDowell Medical Society of Cincinnati, celebrated in a most befitting manner the one hundredth anniversary of Ephraim McDowell's great operation. A tablet is to be placed in the town of Newtown in honor of Richmond's first Caesarean section.—Ohio State Medical Journal.



A Curious Case of Mercurial Poisoning—The circumstances attending the death of a child, which were revealed at an inquest recently held in Coventry, provide a useful lesson on the administration of drugs. The child suffered from ringworm, and the mother, after applying various remedies, consulted the family doctor, who supplied her with a solution of iodine, and gave her a prescription for ammoniated mercury ointment. The mother applied both the preparations to the child's head, with the result that the child suffered considerably, and died a few days afterwards from mercurial poisoning. The result of mixing the iodine solution and the mercurial ointment was the formation of the poisonous salt biniodide of mercury, which became absorbed. The doctor, in his evidence, said his instructions were that the iodine was to be painted on to the ringworm patch, and that on no account was the ointment to be put on the patch at the same time. The jury came to the conclusion that the mother had misunderstood the directions, but expressed the opinion that medical men should give more definite instructions as to the use of prescribed remedies.—The Hospital, London.



CLINICAL NOTES

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL SURGERY.

Bilateral inguinal herniæ that pop in and out of the external rings, are very apt to be direct herniæ. They often contain part of the bladder on one or both sides.

If possible, avoid giving an opiate for an abdominal pain until you know its cause. Morphine may mask the symptoms of an acute lesion, e. g., appendicitis, and delay the diagnosis.

Intratracheal anesthesia (Meltzer) is quite acceptable for operations other than intrathoracic. The etherization is almost automatic, danger of over-etherization is minimized, and coughing, straining and mucous accumulations are obviated.

When operating upon an incarcerated umbilical hernia, especially in an old or enfeebled subject, it may be quite desirable to enlarge the ring by incision before opening the sac. This will facilitate the reduction of the bowel promptly after its exposure.

When applying plaster-of-Paris immerse the bandages, on end, in a basin of water, deep enough to cover, one at a time as needed. As the bandage is lifted out, cover each end with the fingers to prevent loss of the plaster. Squeeze gently and pull off the raveled strands.

If the extremities of the stocking, drawer-leg, stockinette or flannel bandage put next to the skin when a plaster cast is to be applied are turned down over the cast and then a few turns of the plaster bandage are made over them near but not at the edge of the cast, a neat and comfortable cuff or margin will be thus provided.

To account for a chill and pyrexia in a post-operative or post-partum course exclude pneumonia and pyogenic infection before considering malaria. On the other hand, of course, malarial recrudescences are sometimes precipitated by operation and by parturition; and too, it is important to bear in mind that malarial seizures are occasionally marked by vomiting and localized pain and tenderness in the appendix region, easily leading to a mistaken diagnosis.

—o—

Dr. A. D. Bevan, in a discussion of Dr. C. H. Frazier's paper on Exposure of Structures at the Base of the Skull, before the Mississippi Valley Medical Association, October 22, 1912, said: "Novocaine has the advantage that it can be sterilized by repeated boiling without interfering with the strength of the solution. One can infiltrate the neck with an ounce of one-half per cent novocaine

with great freedom from danger and in an ordinary case a much smaller amount than this is quite sufficient."—Exchange.

—O—

Felon—In the early stage a felon may often be aborted with the following:

R̄ Ichthyolis	̄iv
Lani	̄ij
Petrolati	̄j

M. Sig: Apply freely two or three times a day.—Merck's Archives.

—O—

Infantile Colic—Dr. Leonard Williams gives the following prescription as recommended by Widerhofer:

R̄ Tinct. cascarillae	m. x.
Tinct. krameriae	m. x.
Ol. Anthemidis	mj-ij
Syr. simplicis	̄iiss.
Aquam, ad	̄ii.

M. Sig: One teaspoonful every two hours.—"Minor Maladies."

—O—

The Rectum in Constipation.—Medical Summary.—As a rule, cathartics and laxatives are given with a view to stimulating the colon and small intestines when the rectum may be regarded as the main offender. A full rectum is disposed to soon become obtunded in sensibility and its muscular fibers easily acquire a state of atonicity. A narrowed or constricted rectum, due often to obscure conditions, is exceedingly common. The healing of fissures and pile tumors is especially liable to cause cicatricial tissue at the distal extremity with consequent narrowing of the canal's lumen. We have experienced excellent results in cases of obstinate constipation by means of rectal dilatation. This may be accomplished instrumentally under an anesthetic in severe cases. Milder cases are helped by digital dilatation, after which the patient may administer daily self-treatment with a set of dilators made of glass or hard rubber.—Medical Summary.

—O—

Melanotic Sarcoma—H. K. Gaskill, Philadelphia (Journal A. M. A., February 1), gives an account of a case of melanotic sarcoma rapidly developing from a pigmented mole on the left foot which had been treated as a wart and subjected to considerable irritation. After an operation for its removal metastases appeared at various points on the leg and later on the trunk as high as the third rib with the cancerous cachexia, edema of legs, abdominal ascites and

general emaciation. The patient succumbed about seven months after the operation; no autopsy was allowed. Gaskill insists on the importance of viewing with suspicion cases of this type of melanotic nevi, irregular in outline, waxy, smooth, frequently only slightly elevated and of a dark purplish or black color, and of extensive operative measures if they show a tendency to extend and their removal is attempted.

Abdominal Pains—With certain precautions, the general rule that persistent abdominal pain, unrelieved by rest and starvation, requires the abdomen to be opened, will often be the means of saving life, though very rarely it may lead to an unnecessary operation. By persistent abdominal pain, in relation to the acute conditions we are considering, is meant pain with an abrupt onset in a patient who has been in good health, which persists for more than twenty-four hours, although the patient has been kept in bed on the lightest possible diet.

Such conditions as lead colic, tabes dorsalis, tuberculous spine and aneurysm must be borne in mind, and each can usually be excluded by the absence of characteristic signs.

The only condition likely to be mistaken for intestinal obstruction, in which operation will lead to disaster, is the acid intoxication of children.—R. M. Leslie, in *The Medical Press and Circular*.

FROM UROLOGIC AND CUTANEOUS REVIEWS.

Basy again calls attention to a triangular symptom complex of great value in making an early diagnosis of renal tuberculosis, viz., hematuria, nocturnal polyuria, and loss of the urine's brilliancy.

In a severe tuberculous cystitis with bilateral renal tuberculosis, suprapubic cystostomy should be tried. In many instances marked relief of the painful vesical symptoms follows this measure.

In urogenital tuberculosis tuberculin should not be employed if the patient is running a fever of several degrees, has night sweats, chronic diarrhoea, progressive loss of weight, and presents evidences of extensive involvement of the affected organs.

It seems to be somewhat characteristic of adrenal tumors that the pain, if present, radiates upwards and not downwards as the pains of renal tumors or stones. Mayo Robson was the first to mention this fact.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, SEPT. 1913.

No. 9

THE PATHOLOGY OF CHRONIC ARTHRITIS.

LINDSAY S. MILNE, M. D., Kansas City.

Read before the Kansas State Medical Society, May 1, 1913.

There are few diseases in which greater confusion exists as to their nature and causation than those of the joints. Cases of chronic arthritis are so common, so distressing to the patient, and so rebellious to treatment that their study is one of great interest and importance. Yet we find that in any work dealing with arthritis, the subject is most conflicting and uncertain. One finds a whole series of diseases inextricably mixed up under the same name or a variety of designations applied to the same disease. Such names as arthritis deformans, rheumatoid arthritis, chronic arthritis, chronic rheumatism, osteoarthritis, rheumatic gout, infective and toxic arthritis are all indiscriminately applied to a variety of affections of the joints, and to different stages of the same disease.

This confusion indicates a very imperfect knowledge of this group of diseases, a condition which is almost natural considering the great technical difficulty attending the study of their pathology.

Arthritis deformans is a common term applied to this group of diseases, yet if deformity be waited for before diagnosing the disease, the patient may become a hopeless cripple in whose case treatment is no longer of any avail.

Perhaps the most popular present day view of the etiology of chronic arthritis is to consider it as due to some infective or toxic process. Many authors, however, who have advanced opinions along this line have absolutely insufficient proof in support of their contentions. Also, one commonly finds it stated that chronic arthritis depends on some systemic action by toxins elaborated by the intestinal flora, yet no satisfactory demonstration has been advanced as to the nature or action of these toxins.

At the outset of the study of the etiology of chronic arthritis one is faced with the great multiplicity of types which this disease may assume. In some cases there may simply be a chronic synovitis with or without effusion into the joints. In others the opposing bones become adherent, while in other cases all kinds and grades of deformity may be produced. Are all of these types due to different etiological factors or may the same etiological factor in different degrees of virulence and duration be responsible for the production of all the types of arthritis?

The most simple type of chronic joint disease is that which is observed in old age. Here the joints simply become stiff, and often there is a moderate degree of contracture, particularly if the subject has been bedridden for some considerable time. These contractures are largely due to muscular involvement, but they may give rise to the impression that there is an advanced chronic arthritis. In young, very emaciated subjects, dying from some wasting disease, such as phthisis, this stiffness of the joints and contractures resembling the condition seen in extreme old age may be very misleading.

In practically every case, when old age sets in, the cartilage of the joints participates in the general atrophy of the tissues. These changes occur independently of arterio-sclerosis, or are associated with it only in so far as arterio-sclerosis assists in producing the general body atrophy. Degenerative changes in the joints are found with equal frequency in aged subjects, whether arterio-sclerosis is marked or not. These degenerative changes in the joint cartilage are found as commonly in women as in men. Indeed, the joints show degenerative changes in woman at an earlier age than in men, as the atrophy of the organs is more marked and occurs earlier in women. In all the joints of senile atrophied subjects there occurs a simple atrophy of the cartilage, chiefly in the situations normally most exposed to friction, and possibly also where nutrition is poorest. In the knee-joint there commonly is found a patch of cartilage degeneration on the anterior surface between the condyles and also in the center of the under surface of both condyles. In some extremely old subjects, however, the entire surface of the cartilage may become villous. This appearance is due to an atrophy of the superficial layers of the cartilage. Usually it seems to be an irregular process, and extends along the lines of the cartilage cells. It may be observed in all grades, from minute depressions on the surface to deep grooves which give rise to the villous appearance which is noticed on gross examination. In many places, particularly in the smal-

ler joints, the cartilage undergoes a fibrillation, and finally may appear as a layer of fibrous-looking tissue extending over the subjacent cancellous bone. In some places the semilunar cartilages may become extremely fibrillated and frayed out at their inner margins. The articular surface of the patella is particularly subject to degenerative change, and its entire surface may have a villous appearance, while the rest of the joint cartilage is only very slightly involved. The elbow-joints also usually show well-marked changes in old age. Patches of degeneration are common in the middle of the convexity of the lower end of the humerus, and the cartilage may be seen to be receding from the periphery of the articular surface. This recession is particularly evident on the head of the radius, where commonly only the center of the articulating cup may be covered by cartilage. The concavity of the olecranon in its middle part always shows a marked atrophy, and appears as if a band of fibrous tissue separated the articular surface into two lobes. Fissures where the cartilage is atrophied extending across the ulna in other situations are also frequently observed, although the atrophy in the center of the concavity is always very marked before these become evident. In these atrophying conditions the cartilage becomes fibrillated and finally disappears. It may, however, become calcified and changed into bony tissue. In all the joints somewhat similar changes occur. In the acetabulum, for example, the cartilage in the center of the concavity atrophies from the attachment of the ligamentum teres outward, till in many cases as much as one inch in diameter is covered by fibrous tissue only.

In these cases of senile atrophy there are no inflammatory changes associated with the process, as no evidences of inflammation in the synovial membrane or the marrow spaces under the cartilage can be found. The condition follows on similar processes which cause general tissue atrophy in old age, possibly on defective nutrition. It is therefore not a real arthritis, but is perhaps better styled a degenerative arthropathy.

In chronic diseases associated with marked general wasting, occurring at any age, the joints show very similar processes to those found in old age, and consist essentially of an atrophy of the cartilage, and with no inflammatory changes.

True arthritis is essentially an inflammatory process, and its effects depend on the quality of the damaging agent, its duration, and its method of extension to the joint. The same cause may thus give rise to vastly different forms of arthritis, and the mistake must not be made of necessarily classifying similar types in the same etiological group.

There is an immense variety of etiological factors related to the production of arthritis. In the course of certain general infections, the joints may become involved, and many toxic processes seem to have a special selection for the joints. Acute rheumatism, for instance, causes widespread joint involvement. Numerous pyogenic infections—streptococcal, gonococcal, etc.—have the same tendency to cause arthritis, with no involvement of the other organs. Various defects of metabolism are also claimed to be associated with the dissemination of toxic substances which are capable of exciting inflammatory changes in the joints. This last, however, is by no means proved as these toxins have not been determined. It is also more probable that the digestive disturbances which so frequently go along with arthritic cases are due to the same general infection which has damaged the joints, or that the abnormal intestinal condition admits of the dissemination of bacteria into the circulation, and in this way infects the joints. In this connection it is well known that in many cases of dilatation of the colon there is an associated bacteraemia particularly of the bacillus coli. In the history of a case of chronic arthritis it is surprisingly frequent to find such conditions as chronic pharyngitis and tonsillitis, pyorrhea alveolaris, endometritis, nasal sinus infection, mastoiditis, chronic gonorrhoea, chronic phthisis, or some other existing septic focus which may have important relationship to the etiology. Certain of these infective agents may act in the form of irritative toxins in the same manner as gout, where uratic crystals are deposited in the cartilage, and which may sometimes excite secondary inflammatory reactive changes in the synovial membrane and marrow spaces subjacent to the joint cartilage, and so produce a true arthritis. In the bulk of cases, however, the inflammatory changes which can almost invariably be observed are due to a lodgement of bacteria in the joint structures. As a farther clinical proof of the infective nature of arthritis deformans cases, it is by no means uncommon to find some swelling of the lymphatic glands and enlargement of the spleen. These are particularly evident in those cases of chronic arthritis affecting children, generally known as Still's disease. Arterio-sclerosis has been claimed by many to be a direct cause of arthritis, yet numerous cases are observed without any marked arterio-sclerosis. Arterio-sclerosis undoubtedly may be produced by the same factors which are also causing arthritis, but it has no direct bearing, as some claim, on the production of joint inflammation. Microscopic sections of joints in arthritis cases do not, as a rule, show arterio-sclerosis and the condition does not seem

to depend on any decreased blood supply from the larger arteries of the bone marrow.

Similarly, without any conclusive proofs either therapeutic or pathological, it has been stated that arthritis deformans cases depend on a deprivation from the system of lime salts.

The milder grades of joint infection, such as occur in rheumatic fever, cause an inflammation in the synovial membrane, congestion of the vessels beneath the cartilage, and generally an effusion of serum into the joint. As a rule, one might say invariably; in acute rheumatic fever due to the specific organism of that disease, this resolves completely, and chronic synovitis and persistent effusion does not result as in the more severe forms of arthritis. In the pyogenic infections—streptococcal, gonococcal, etc—the same course may be taken and result in complete recovery. Even purulent effusion may occur, and yet the joints may suffer no permanent damage. In animals, particularly rabbits and cats, the joints may be injected with cultures of low-grade virulence and extensive purulent effusion may be produced, yet the joint cartilage may remain undamaged. Where the infection is more virulent, as may be observed after injections of fresh cultures of organisms—*bacillus coli* for instance—into the joints of dogs there are marked changes produced in the cartilage. The vascular structures underlying the cartilage become engorged, giving a reddened appearance to the cartilage, and serum is exuded from them through the cartilage toward the joint. The cartilage cells along the lines of the exudation of the serum from the subjacent vessels become swollen, disintegrated and their capsules distended. In other degenerated areas produced in this way leucocytes and their granulation tissue rapidly extend towards the surface of the cartilage and should the irritant continue in unabated virulence the cartilage soon becomes destroyed and replaced by fibrous tissue. In the more severe types of infection the entire joint surface may be involved. In the milder varieties, however, the process tends to be more localized. A common appearance in cases where the animal has survived the infection of the joint is to find after ten days or so that the fluid in the joint, previously purulent, is clear and the synovial membrane is congested and villous in appearance. This may be the only change. In those cases, however, where the infection has been more severe the cartilage in several spots is apt to be pitted, where granulation tissue has extended upwards from the subcartilagenous vascular structures. Certain observers of arthritis in human cases have considered that simultaneously with these changes there occurred an extension of granulation tissue

from the synovial membrane at the periphery of the articular surface, and this pannus spreading over the cartilage destroyed it as it advanced. This, however, is, so far as I have observed, in relatively small amount in experimental infections of joints in animals, and with no degree of certainty can be noticed in human cases.

These subcartilagenous inflammatory extensions through the cartilage may become continuous, and form a complete layer of fibrous tissue on the articular surface of the bone, or the subcartilagenous reaction may destroy the cartilage in patches of varying size. Should the opposing bone of the articulation be undergoing similar changes, and no excessive fluid separate the two surfaces, particularly also if movement be limited, the two layers of fibrous tissue may unite and finally lead to complete fibrous ankylosis, which eventually may become a bony union.

This adhesive type is one of the commonly observed forms of chronic arthritis. The processes which lead to deformity of the joint are produced in very much the same way. These further changes taking place in such joints and which may lead to deformity depend on several factors. Perhaps the most important of these is whether the causal condition has terminated, or whether destruction and consequent new formation of tissue are continued or repeated. It is this progressive destruction and proliferation of new tissues which eventually is responsible for the extreme deformities which are so common in chronic arthritis. Another factor which must not be neglected is the tendency of all the joint structures, the synovial membrane, the cartilage both perichondrial and hyaline, and the endosteal tissues in inflammatory and proliferative states, to metaplasia. In all cases of arthritis the synovial membrane shows considerable reaction. At first it is simply congested, later its lymphoid structure becomes hyperplastic and it assumes a villous appearance. Fibrous changes may occur in these villi, and finally cartilage or even bone may be produced. The loose bodies found in so many arthritic joints are chiefly composed of cartilage or bone, and for the most part are detached inflammatory metaplastic synovial proliferations.

Cartilage is thus more or less interchangeable with fibrous tissue. It is not uncommon to notice when the joint cartilage is becoming atrophied that it becomes calcified or transformed into a fibrillated structure, closely resembling fibrous tissue. Also perichondrial fibrous tissue commonly becomes changed into typical hyaline cartilage. The deeper layers of the cartilage may also proliferate, forming large nodules of hyaline cartilage or bone.

The greatest metaplasia, however, is found in the subcartilagenous inflammatory process, where bone or cartilage as a rule tends to be formed.

It would appear, then, that the possibilities resulting from severe infection of a joint—streptococcal, gonococcal, etc—are very numerous. Complete recovery is possible, even after the joint has been distended with pus. The synovial membrane may become thickened and villous, continuously providing a source for the exudation of fluid into the joint. Some of these hyperplastic villi may become cartilagenous and some may break loose into the joint and form the loose bodies so commonly found in these cases. With even marked chronic synovial inflammatory changes the cartilage may remain undamaged. The cartilage may be, in whole or in part, destroyed, depending on the intensity and duration of the infection and the amount of inflammatory changes induced in the subcartilagenous marrow spaces. The cartilage is destroyed in front of the inflammatory proliferation extending from a comparatively narrow layer of inflamed marrow spaces immediately subjacent to the cartilage. The cartilage thus, in part or altogether, may become replaced by fibrous tissue, which also may unite with similar productions of fibrous tissue on the articular surface of the opposing bone and so produce adhesions. It is in this way that the adhesive types of chronic arthritis are produced. These adhesions may naturally be localized to a few spots, or may be distributed uniformly over the entire articular surface. Secondary changes in this new tissue are also possible, although generally the process remains stationary at the fibrous adhesive stage. Bone and even cartilage formation may, however, occur, and eventually the joint may be obliterated by complete osseous union between the opposing bones.

The earlier stages of the less acute, progressive forms of arthritis often appear as small depressions on the surface of the cartilage. These degenerated areas are generally associated with an inflammatory focus in the subjacent marrow spaces. The primary agent causing this may originally have settled in this position in the epiphysis, or have extended through from the joint. These subcartilagenous inflammations are, however, commonly found some little distance away from the cartilage, which suggests that the primary involvement of the joint is, in many cases, from the direction of the epiphysis. The degeneration of the cartilage over these areas is probably due to some local interference with nutrition, but it may be produced in some way, as can be observed to take

place in acute arthritis, by the extension upwards of substances which destroy the cartilage.

The endosteal cells lining the marrow spaces included in this inflammatory process tend to produce metaplastic changes. Cartilage formation is frequently observed in these areas. They may also be transformed into an osteoid tissue, which eventually may become dense bone.

The inflammatory tissue in the marrow spaces tends to extend upwards through the degenerated cartilage, and spread out for some distance on the surface. In this way a wider area of cartilage may secondarily become destroyed. In some cases there is found a comparatively large portion of atrophic fibrillated oedematous cartilage, and only a comparatively small focus of inflammation in the underlying marrow spaces, which probably has been the primary condition.

In more advanced cases the cartilage appears to have become completely destroyed, and is replaced by fibrous tissue. As a rule, this process is localized. Islands of cartilage usually persist even in the most advanced cases, and are particularly evident towards the periphery of the joint surface. In the old-standing cases these cartilage remnants appear to become hyperplastic and nodular in appearance. Where the cartilage has completely disappeared, particularly in those situations most exposed to friction, the subcartilagenous tissue tends to become transformed into osteoid tissue by the action of the endosteal cells. Finally, this osteoid tissue becomes dense bone, which, to the naked eye, appears eburnated. Not only is this subcartilagenous inflammation associated with cartilagenous degeneration, but the bony trabeculae of the inflamed region become atrophied by a process of osteoclasia. In those advanced cases, where the involvement of the joint is extensive, the joint surface is really wholly reconstructed, the original cartilage having completely disappeared. As these processes are irregular, and as portions of cartilage persist, the surface of the joint becomes very uneven. This new fibrous tissue tends to become transformed into bone, thus the articular surface may come to be represented only by a fibrous thin layer of tissue extended over a sheet of dense bone. In situations exposed to friction this bone becomes exposed on the joint surface, and becomes extremely dense and eburnated. In some severe cases the entire articular surface of the bone seems to be transformed into an irregular, pitted layer of bone. This might represent what is often termed the atrophic type of arthritis deformans.

The portions of cartilage which have escaped destruction

generally show some proliferative change. The perichondrial layer plays an important part in this regeneration of cartilage, but the deeper layers of the surviving joint cartilage are also particularly liable to form hyperplastic nodules of cartilage, as is frequently seen in old-standing cases of arthritis. These masses of cartilage, whether derived from some persisting remnant of the original cartilage or from a metaplasia of endosteal inflammatory tissue, may assume a very considerable size indeed.

In some cases very marked deformities seem to result. To a large extent this is due to a combination of extreme destruction, and almost equally pronounced hyperplasia of the tissues which can form cartilage and bone. In this way luxations and ankylosis without adhesions are produced, the so-called hypertrophic form of arthritis deformans.

A great variety of conditions may then be responsible for the production of identical clinical and pathological types of joint disease. Also very varying types of arthritis may be produced by the same etiological factor, depending on the severity and duration of the infection. Thus in gonorrhea for example, almost every type may be produced. A simple serous or purulent synovitis which completely recovers to a chronic synovitis with or without effusion are common occurrences. The cartilage may or may not be damaged. The extent of damage to the cartilage may be very variable, from a few pits on the surface to complete bony ankylosis or marked deformity from cartilagenous and bony destruction and proliferation. The inflammatory process may be limited in a short space of time or may be progressive for years, producing every typical appearance of the worst cases of arthritis deformans.

At any stage in these processes, which are responsible for the production of arthritis deformans the disease may become limited with the cessation of the particular etiological factor, and, clinically one can observe cases which have become stationary in every conceivable stage of the disease.

In most cases of chronic arthritis the inflammatory processes in the marrow spaces occur in a somewhat limited region immediately subjacent to the joint cartilage. Sometimes, however, they are more widespread in the bone and a real osteoarthritis is produced. In such cases very marked irregularities on the surface of the bone, even some considerable distance away from the joint, may be produced.

In Charcot joints as found in tabes there is perhaps greater deformity than in any other joint disease. To some extent this

condition may be due to some nervous atrophy, but inflammation plays by far the greater part in its production. In these Charcot joint cases, there is generally a very excessive synovial reaction. The synovial tags are very large, often pedunculated, and frequently more or less cartilagenous. There also are generally found large numbers of rounded cartilagenous or bony loose bodies in the joint, most of which have been derived from the synovial villi. The articular cartilage has for the most part become disintegrated and its place taken by fibrous tissue. In parts, however, this tends to become eburnated, following the formation of new bone by the endosteum of the inflamed subcartilagenous marrow spaces. Towards the periphery of the articulation, the cartilage, where it has escaped destruction by the inflammatory process, tends to become extremely hyperplastic and form large cartilagenous nodules. Not only are these Charcot joints essentially produced by some inflammatory process, but in certain places this has a very definitely syphilitic type.

There are, however, very marked atrophic changes in the crucial ligaments and in the bony trabeculæ, so that nervous atrophic influences are also important factors.

In tuberculosis of the joints very much the same series of events may take place as in the other forms of arthritis. The tuberculous process may, and often does, settle down in the synovial membrane and produce a chronic synovitis with effusion into the joint. In such cases there may be no involvement of the bones and therefore no bony deformity. In many cases, however, the tuberculous infection begins in the layer of marrow spaces immediately subjacent to the joint cartilage, as does many of these infective agents which also tend to produce chronic arthritis. The tuberculous process extends up through the overlying cartilage and so produces the characteristic carious appearance of the joint surface in such cases.

It may then be surmised that practically all cases of chronic arthritis are invariably due to some infective agent and the great variety of types depends largely on the severity of the infective agent and the duration of time to which the joint is exposed to it. In any event definitely inflammatory lesions either in the synovial membrane or in the marrow spaces under the cartilage account for all the characteristic changes in the joints in all the forms of chronic arthritis.

An understanding of the pathology of arthritis is essential to the successful treatment of this condition. Some inflammatory focus may be discoverable which may be the etiological factor,

and by the cure of this condition the joint disease may become limited or cured. Even after the disease has become far advanced, its progressive character can be arrested, various orthopedic measures may be adopted which can vastly improve the condition of the patient, and the functions of the damaged joints.

— 0 —

SOME RECENT MEDICAL LEGISLATION—THE REMEDY—WHAT?

DR. F. A. CARMICHAEL, Goodland, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

Because of a conviction born of precedent, I have always regarded the introduction of politics into the columns of a Medical Journal as prejudicial to its best interests, and a serious handicap to its scientific efficiency.

In perusing the pages of the March and April Journals, however, I was impressed with the utter childishness of the protest against, and criticism of the action of Governor Hodges, relative to the Chiropractic Bill.

Considering the fact that it is a human frailty to place the blame of our calamity on the shoulder of the other fellow when possible, we will usually hasten to saddle him with the responsibility of our own delinquencies, no matter how far-fetched or inadequate our grounds for so doing may be.

As a matter of fact it is my conviction that the profession got just exactly what it was entitled to under the present legislative acts, and I further believe that the chiropractors received nothing more than they bought and paid for. Referring to the first statement, I may say that no more self-contained and self-centered individual than the average doctor exists. Launched upon his professional career with exalted ideals and a firm conviction of the nobility and highness of his calling, he soon becomes to regard himself as something apart from the social and civic problems of his environment, and utterly lost in the study and pursuit of his profession, fails to recognize in the signs of the times, the influences that portend the enactment of just such pin-head legislation as we have recently experienced. History repeats itself year after year, and year after year finds the doctor sublimely confident that proper legislative enactments will be secured for the protection of the Public, and supinely indifferent as to who accomplishes these enactments just so that he is not called upon to divert his

energies from their accustomed channels, and year after year brings its usual budget of disappointments, yet he seems to gain no wisdom from past experience, but is super-endowed with that "hope that springs eternal." He can never be made to comprehend that he is in any way responsible for these disappointments.

The average physician prides himself on the fact that he is a public educator. The modern slogan of the profession has been, "Educate the people," "take them into your confidence." "Rob the treatment of disease of its mystery by explaining fundamental principles to your patients, and thereby gain their confidence."

This campaign of education has seemingly resulted in no increase in the esteem, respect or confidence of the people in the medical profession, as through their legislative representation they have chosen to open wide the gate for the entrance of every form of graft and fake that chooses to masquerade under the cloak of the healing art and have made a jest of the medical profession. Not wilfully, not maliciously, but through an ignorance so dense, a superficiality so glaring that it will go down in history as the most flagrant betrayal of the sacred trust of a people, that has ever been recorded in the transaction of any state legislature; and what have the 2688 physicians of the state done to protect the people and the profession of the state?

As usual, they have done nothing. A few, a very few of the more aggressive and public spirited, have given time and effort backed by the encouragement of the Kansas State Medical Society to preserve the integrity of the State Board of Health, when assailed by the food adulterators, and to do what was possible to stem the tide of freak legislation, but how pitifully weak must this effort have been, when opposed to the years of close organization, incessant wire pulling, adroit administration of a handsome fund for lobbying and a stupendous line of talk calculated to be gulped down and passed without digesting, by our ever burdened legislators; and the people of the state and particularly the medical profession have been handed the ultimate end product of this love feast in the form of the Chiropractic Bill, with its board of three chiros, a preacher and a school teacher. Fine, isn't it? The physicians of the state have been rewarded in direct proportion to the energy and zeal manifested by them in combating this measure. Does it require a therapeutic Tom Lawson to prescribe "The Remedy"? Hardly, but doubtless the remedy will be administered with the same promptness and vigor that we exhibited in employing prophylaxis.

Nearly two years ago through the columns of the Journal, I

predicted the passage of this legislative act and urged an organized opposition. Hundreds of physicians throughout the state knew that the issue was pending, and what did we do? Nothing, or practically nothing; it amounts to the same thing. The great rank and file of the profession of the state, like that other biped the ostrich, buried its head in the sand of its personal conviction, that nothing would come of it, while their rear elevations were exposed to the inspection of the house and senate and commented upon (presumably without prejudice) by the drugless "heelers."

Obviously the attitude as well as the view, was not calculated to inspire either confidence or favoritism on the part of our legislators, hence the Chiropractic Bill.

In reference to the second statement, that the Chiroso got no more than they bought and paid for. I do not wish to be misconstrued. Their victory was bought by organized effort, by the employment of "Every wile (un) justified by honor," by unstinted financial help to keep their machinery well oiled, by a corps of smooth and unscrupulous lobbyists, and paid for in ceaseless attention to detail, a never sleeping vigilance, and constant touch with every member of the legislative body, all of which may be summarized in the words, "perfect organization."

The profession and the people alike have clamored for higher standards of preliminary and medical education. State Boards have vied with one another in subjecting applicants for licensure to the most rigid examination as to their qualifications to practice, that the public safety as well as the honor and ethics of the profession might be safe-guarded. These measures we reinaugurated within the ranks of the profession, and so necessary were they deemed, that a portion of the work of the Rockefeller Foundation was to elevate and standardize the system of Medical Education in the United States.

While our energies have been directed to this accomplishment, those of the Chiropractic Grafters have been concentrated upon gaining recognition by the state. We have succeeded in our efforts to secure higher medical education among the medical profession. they have succeeded through our legislature, in prostituting the state by opening wide its portals to a class of ignorant quacks and shameless grafters, beside whom, the cancer cure fake and sure cure for consumption ghoul may be looked upon as public benefactors, and welcomed as desirable citizens.

I do not believe that there has been a man in the state more active in combatting the activities and controverting the pretensions of these contemptible leeches who feast on the credulity

and filch the substance of a suffering and deluded populace, than myself. In private and professional life, in the lay and medical press, I have sought to show the people how irrational and baseless were the claims of these 60-day healers.

I have been shamed, humiliated, almost crucified on the cross of my own self-respect, by being invited to participate in a joint debate with a louse-brained demagogue and professional haranguist from Davenport, Iowa, the self-styled "fountain head of chiropractic," and the son, I believe of an (in) famous cancer cure quack. I am told that the senate committee to whom the chiropractic bill was referred, was favored by an exhibition of expert wind jamming by an importation from Oklahoma City, secured to convert this committee to the miraculous value of having their spinal nerves properly "adjusted", and that it was the bubbling and babbling confidence in the all healing virtue of spine juggling, of this hot air manipulator that convinced this learned, judicial body of the crying need and legislative wisdom of loosening the purse strings of a confiding constituency to their rapacious grasp.

I have been reliably informed that a member of the senate committee to whom this bill was referred, made the positive statement to that committee that he had suffered from appendicitis and that a chiropractic operator, "had rubbed his appendicitis out" after numerous doctors had failed to give him relief. We are forced to the conclusion that if this statement was not made "for a consideration", then the proper place for a man with the mental caliber of this individual is not in the state senate, but in a home for the feeble minded. Did not the profession of the state have the same privilege of appearing before this committee and controverting, as they could easily have done, the baseless slush of these charlatans? Why didn't they? Simply because they lack that energy that is the natural outgrowth of proper and efficient organization. Because the profession wishes to sleep a little longer, and revel in its beautiful theory of the mightiness and ultimate prevalence of truth.

Therefore, why censure our governor and stigmatize the act as "ingratitude", when he fails to veto a measure that presumably (to him) represents a popular demand on the part of the people, whose best interests his official oath obligated him to conserve? Would we expect him to place his individual judgment above that of a majority of the House and Senate, on a measure that involves no question of administration policy?

Let us come back to earth and place the blame where it rightfully belongs, on our own indifference as a profession, to the pub-

lic welfare. Now that this anencephalic and acardiac monstrosity, begotten of criminal cupidity and nourished in the putrid slime of unscrupulous charlatanry has been legally born into our state under the mid-wifery and sponsorship of our legislative wise-acres, what? Experience teaches us that vicious legislative measures when enacted into laws and placed upon our statutes are usually as enduring as the Rock of Ages.

Our health and sanitation laws may be amended to suit the passing whim of the legislature and coordinate with the financial interests of the food adulterators. The butcher, the baker, the candlestick maker and the dog catcher may, and probably eventually will, constitute the personel of our Board of Health, but this erudite board of three chiros, supplemented, augmented, half-soled and reinforced by the minister and the school teacher, will go skipping down the dim vistas of state history in utter security.

It might be pertinent to observe in passing, that the tenure of office of the minister or the school teacher, would be about as extended as the integrity of a snow.ball in that region of height and constant temperatures, should they, in the slightest manner dissent from the opinions of their associates, *The Three Graces*.

Now, it seems to me that there are several important questions that the medical profession of this state should ask itself and answer; several straight from-the-shoulder truths that it should face before it settles down to a serious consideration of the recent legislation affecting medical education. Granting as we must, the active agency of the medical profession in the election of the present governor.

1st. Is it either good taste or business policy to be continually flaunting this fact in the face of the governor and the public, through columns of the Journal? Observing, as we just have, the results of an active campaign properly conducted, to the interests of which the public press and popular magazines have been utilized in which energy and finance were present in abundance and in which the evidence of an efficient organization has been demonstrated in legalizing in this state, one of the most contemptible, most shallow and unreasonable, as well as the most ignorant and pitiless graft of this or any other age.

2nd. Would it not be well for the medical profession of this state to draw a moral from this? Would it not be well to make a single unit of efficiency of this quasi social, semi-organized and palpably indifferent society? Is it not a proper time to take stock of our material and resources? Of the 2688 physicians of the state, how many of them have contributed even their moral

support to the maintainance of an efficient state, county or district organization? How many of those who maintain their standing in the state and national organization through affiliation with their local society, are of any actual benefit to any of these societies? Out in my portion of the state, the physicians are of that type that the only way that 80% of them could be induced to attend a medical society meeting, would be to send out a posse of brave and determined men and bring them in dead, but so long as they had the power of resist, you would not find them there. Many, in fact the majority of these men are members of some society, but as far as their psychic or moral influence to that society is concerned, they are dead ones.

Now, we may go on in the same old way at our medical meetings—Dr. Jones may read an exhaustively scientific treatise on the treatment of ingrowing toe nails, and Dr. Brown an able exposition on the latest in sanitation and disease prevention and be applauded by this learned body. The chiropractic will tell the confiding public whose super-credulity must be nourished on some idiotic fad or balderdash, that by slightly adjusting the innervation of the coccygeous muscle, he will cure their ingrowing toe nail, that hygiene and sanitation are entirely unnecessary so long as they suppress the natural tendency of their vertebrae to unjoint every time they sneeze, and have their nerves adjusted to a proper and harmonious pitch.

Now, let us glance at this organization of ours to see just how valuable it is. Less than 50% of the profession of the state are identified with the state society. According to the directory A. M. A. 1060 of the 2688 physicians of the state are identified with the state organization, and judging from the enthusiasm manifested by these in the western portion of the state, not more than 25 % of these who retain membership are active members, willing to contribute time, talent and money to the cause. Were our business and protective organization as creditable as our scientific programs there would be no cause to complain, but from a stand-point of benefit to the physician himself, aside from the profit and pleasure of its scientific communion, we have and always have had a business organization whose inefficiency is a standing joke.

The members of the medical profession who, as members of the house and senate have struggled against the opposition and prejudices of these bodies, should be able with very valuable suggestions as to our future methods of procedure.

It is my conviction that in the future, we should not make

economy in the administration of this organization paramount, but should rather concentrate all our energies toward making its protective functions more efficient.

Our membership should comprise not fifty per cent or less, of the registered profession of the state as it now does, but every reputable practitioner in the state should be made to see his duty and to perform it.

The yearly dues to the state society, instead of being the paltry sum that is just sufficient to keep our organization from bankruptcy, should be sufficient to have a handsome balance in our treasury that could be utilized under the direction of the executive board to meet contingencies such as those we have recently encountered. A fund of \$20,000 might this be easily raised, the interest on which would go very far toward keeping up the running expenses of the society, and after this fund has been raised, yearly dues of \$5.00 per year for five years would put our organization on a financial basis so firm that its influence and power would be increased fifty-fold.

Such an arrangement, while it may sound unique to you is perfectly feasible, and easily accomplished, and would, I believe, arouse the personal and intimate interest of the profession of the state as no other measure would. Such a plan would enable us to own and operate our own printing plant, thereby increasing its scope and value to the profession of the state. It would enable us to print and circulate such literature and facts as might be necessary for the enlightenment of the public and profession, would give our state society a better chance to co-operate with, and encourage its component societies throughout the state and offer a more effective protection to the profession.

The belief that charlatanry will eventually work its own destruction has not been borne out by past experience. In fact there is nothing to indicate that it has ever been so rampant or so aggressive as at the present time.

It therefore becomes a duty of citizenship of every member of the medical profession of this state, to whose indifference and inaction the recent legislation with its deplorable results, may be largely charged, to make an earnest effort to repair as far as possible, the results of this indifference, and this effort should comprehend more than an empty and bootless discussion of the subject or the expression of our individual or collective dissatisfaction, and I believe that an effort should be made at this time, looking toward such a financial endowment of this organization, as will insure its future potency in the struggle in which the profession of the state must now engage.

THEORETICAL VS. PRACTICAL POLITICS IN MEDICAL LEGISLATION.

DR. J. J. SIPPY, Belle Plain, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

The first requisite of every true physician is a receptive, judicial temperament. He must be theoretically able at all times to weigh arguments deliberately and without sentiment. How far each of us is capable of so doing depends largely upon our habits of thought and self-control. At this time and in the light of events of the past few months, no one better than the writer appreciates the delicacy of choosing words and thoughts which will not rankle or leave a sting, and which may be accepted in the argumentative, analytical sense in which they are offered.

The writer further wishes to state in all candor, that he has always been affiliated in a political way with the party now in control of the destinies of Kansas, temporarily at least, but aside from that fact is deemed otherwise mentally competent. Furthermore, he has attempted to forget it in this paper and the subject matter following is offered as nearly as his process of ideation will permit, without bias and without personalities. He has endeavored to avoid personal criticism, and has nothing in view but the best interests of the medical profession, and the public at large. In fact, his appearance in the political arena has been through the sole idea of furthering medical and public health legislation, and all his energies have been directed in that line. Needless to explain to the sophisticated that professional political activity is without profit, i. e., financially, even with the compensation of winning, and is not to be recommended except as a diversion to be placed in the same category as poker and ponies; to the man who feels he must have excitement as a stimulant, and who has no qualms concerning poor-farms and old-age pensions. For confirmation reference may be made to any and all members of this body who have held elective and appointive positions on the state pay-roll.

You will note that the words "professional political activity" are used advisedly, for a certain member of that honorable body, our state senate, became highly indignant a short time since, when members of the legislature were inadvertently referred to as "professional politicians." He resented the application by stating that the term was exclusive, when it should be inclusive, for he said it was a matter of common knowledge from Maine to Cali-

fornia that every male and female within the borders of Kansas is a "professional politician" from the first inspiration to the last expiration. Perhaps he was right, and he might have stated further that the fluctuations of the turbulent Kansas air currents are equally as stable as the Kansas political complexion.

But it is believed that he overlooked one set of men who have no right to the classification of professionals. It is estimated there are twenty six hundred practitioners of medicine in Kansas. At least twenty five hundred of them are amateurs of the most amateurish class of politicians, and probably this estimate is too low by one hundred. It is unfortunate but true, that in times past, not only public sentiment, but that of the medical profession as well, has placed a ban on the physician entering the field of politics. This has not entirely disappeared and most physicians hesitate in being identified with anything political. This one fact is probably the greatest reason for the general lack of support given to medical and public health legislation. The ethics of medicine demand that the physician wait for clients to come to him, and having acquired this sense of modesty to an exaggeration, he is prone to carry it to other lines and make himself believe that eventually all things will come to him, even to legislation, without effort on his part.

Just why a physician has no right to meddle with politics is beyond the comprehension of the writer. It is asserted that the physician who is a success in a professional way has absolutely no time for anything but his work. Probably this has been true under the old regime which taught that all medicine lay in the treatment and cure of disease. But the new idea of prevention as well as cure, must of necessity lead into legislation, and the physician today can no more dodge the responsibility of politics than the cure of disease, for the welfare of his clientele demand both. Some argue that education of the public will effect the necessary reforms. It will, but it's a slow process. Legislation is often the shorter route, and even preceded by education is ultimately required. The Texas border slogan was "shoot first—explain afterward," and the rule holds good with the larger per cent of the public in even this argument.

It is to be noted that the school-teachers, farmers, laboring men, and all the other trades and professions have no hesitancy in entering politics to protect their interests. The public concedes that right to them, for they are the public. The larger corporations are zealously active in every session of the legislature. So

why these platitudes? The physician has a right in politics, and if he does not break in, he is derelict in his duty to his patients and to the neighborhood in which he lives.

And here again comes up the old discussion which makes political parties, for differences in parties is not what constitutes the ultimate end, for usually all are agreed on that, but how to achieve that end. It follows therefore that medical men will also disagree, politics as well as medicine, and having acquired both by inherent ego and thorough training the highest finesse in that venerated custom on which hangs all medical wisdom and individuality, of disagreeing with his fellows on all points in the latter art, it is to be expected that they are the preeminent 'disagreeors' when it comes to the former.

This may be ascribed by some as being due to the isolated method of thought and work which each physician pursues, but observation demonstrates that the maximum of turmoil in medical thought and opinion is always present where the medical population is greatest. Students of this condition have suggested organization as the remedy and as a result we have the various associations and societies. In times past these have existed as scientific bodies alone, but the needs of the hour are yearly making them more practical. They still lack, however, the cohesiveness and working capacity they should possess to obtain results, and while we do have an enthusiastic body of volunteer soldiery, it is composed of raw recruits, untrained, undrilled and in the hour of active fighting, an undisciplined mob, wasting ammunition and aimless exhortation and achieving Bull Runs.

All of which, if digression is permitted, is exactly what happened in the past few months. A resume may not not be out of place.

Along in the year of 1911, one of our Kansas Medical Societies, and all honor is due them for their pioneering, took umbrage at the editor of one of our Kansas dailies, because of his flagrant flaunting of fake medical advertising in the columns of his paper. Not that he was any worse than the average editor, except that he seemed to be in luck to have more of it, and thus derived more profit, by reason of which all the other editors were rendered envious, but because this particular editor had announced himself as a candidate for gubernatorial honors. Furthermore his announcement to the effect contained the assurance that he was extremely solicitous for the welfare of the people, and that he had no other ambition than to serve them and protect them from grafters and wolves of commerce who sought to prey upon them. All

of which in view of the management of his advertising department from the standpoint of the medical man who is thoroughly alive to such graft was extremely deplorable, and the society immediately informed that editor of its lack of faith in his sincerity of purpose as expressed in his platform. A characteristic of all good medical societies is never to adjourn without at least one set of resolutions, to which few listen when it is read and all forget when it has been read. This set of resolutions however was different. It was listened to, and as circumstances afterward developed, started some fireworks. For the editor, if the information is true, on receipt of the various 'whereases' promptly informed the committee drafting the same, as to where it might head in. Such a declaration might be expected from any man with an ounce of fighting spirit or backbone, who is over twenty-one and always been considered by his bankers as capable of managing his own affairs, and was certainly his privilege as an editor. But as a candidate for a high office it was not diplomatic, and as the dignity of every medical man in the state suffered by reason of the affront, so the great majority of the medical men were 'forninst' him. He was made the goat of the campaign, and when by a series of other combinations his opponent was elected, the profession heaved a sigh of relief and self-satisfaction, and felt that it had saved the day, and that the fortunately elected one owed it his political life and eternal gratitude. Just how much gratitude the profession is entitled to from our present governor is a matter of much argument, but in view of the dreadful chaos of the last campaign, the extremely narrow margin by which he was elected and for which most any one may assume credit, and the various other important factors and professions involved, it is up to every member to decide for himself.

In the strenuousness of the campaign however, the most important fact was overlooked by the majority of the profession, and this one point is to be commended to your recollection for future campaigns, viz., the executive of our government does not make our laws, but has only the power to approve or disapprove, and in nothing short of a public calamity is he justified in assuming the latter course. Fully 95% of the members of the legislature which does make our laws, were allowed to slip in without a single declaration or promise of what they proposed to enact in the line of public health and medical laws.

It is contended by many statesmen of the present day that this nation of ours has outgrown the swaddling garments of 1789, and that the Constitution then adopted is no longer adequate;

in fact no man of today in political life may claim the title of statesman, until he has invented some scheme to tinker and remodel that instrument. It still survives however, and among its many features is contained the assurance that every citizen is entitled to the freedom of thought and speech, of which every American is never slow to take advantage, and to exercise that inalienable privilege of denouncing everything which he doesn't fully understand and which does not seem to return to his personal benefit a direct pecuniary advantage. We have a veritable Reign of Terror in the prosecution of the 'trusts', and every combination, whether for or against public benefit, for whatever purpose is immediately branded as such. And as in the days of the Reign of Terror in France, it seems easy for any body of rogues to rid itself of an atagonist by the simple method of denouncing it as a 'trust'. Is it strange then that the medical organization should not be exempted among the large list of undersirables?

You may smile at the absurdity of the accusation, but nevertheless "The National League of Medical Freedom" takes itself very seriously and exercises its full constitutional privilege of saying what it pleases about us. No one seems to be clear as to its personell or its backing, but it numbers its thousands of members and seems to lack no financial assistance. Furthermore, it does its work systematically and never takes a vacation. It maintains headquarters in every state; its campaign lasts all the year round, and if any of you take the trouble to inquire as to its ramifications in your own community, you may be surprised to learn as the writer has, that many of your best friends are enrolled on its membership list, and are being insidiously poisoned by its literature. It takes what it can get; its publicity bureau never misses an opportunity to insert in the press any news which bears malice toward the medical profession. Is espouses the cause of every 'ism,' 'pathy' or 'cult,' that is opposed to the art of medicine, not because it feels any friendship for them but because each means another ally to harrass a common enemy, 'the Great Medical Trust.'" To what end it profits thereby you may surmise. The great food manufacturers and patent medicine concerns which conform reluctantly to the Food and Drug Regulations, the owners of insanitary tenements which are paying good interest on present investments, the fake practitioners who prey ghoulishly on the sufferings of humanity, the exploiters of child labor and white slavery, and various others are merely suggestions which to the altruistic physician laboring for ideals, may seem a bit startling. But the element of greed is there, and unfortunately it does mis-

lead vast numbers of well-intentioned citizens, who have not yet aroused to the fact that they are being used for cats-paws. And the poison though subtle is spreading and will continue to spread unless combatted.

Its influence and growth in our own state is almost beyond belief, but it is playing an important part in politics. Not openly perhaps, but to those who were on the ground during the session of the last legislature, its crystallization of sentiment in bitter opposition to everything in the way of public health and medical legislation, was a revelation. The profession complacently regarding itself as a maker of governors, and blindly disregarding the warnings of those who were more familiar with the machinations of the "League," smiling at these warnings as the vaporings of disordered minds, was hardly prepared for the savage attacks made all along the line, and day after day. It expected to make advancements in legislation—it fought to save what little it could in defeat.

Besides the bills providing for the separate osteopathic and chiropractic boards, no less than five different bills, were introduced to re-organize the board of health, every one of which would have meant a practical destruction of its present efficiency. Some several more were introduced intending to nullify the Food and Drug Act. Still another, a committee bill, in its intent meant the repeal of the medical practice act in its entirety. The itinerant vendor of patent medicine instead of being restricted, was if anything given more privilege. Funds for carrying on the work of medical education at the University School of Medicine and of the Board of Health were wrung from the committees on Ways and Means like pulling eye-teeth. It was even necessary for the plucky, fighting medical men who were representatives in both houses, to carry an appeal to the floor of the house to augment these, and even with what was then obtained, the work of both is sadly crippled for the ensuing biennium. The bill providing for a State Tuberculosis Sanatorium and the appropriation therefor, was entirely repealed in the upper house at one time, and was only rescued in the closing hours of the legislature by extraordinary efforts. The work of hotel, restaurant and barber shop inspection properly correlating with the work of the State Board of Health, was taken from it and placed under separate departments. The rewritten Quarantine Bill was buried under a mass of ridicule led by an ardent Christian Scientist.

All this retrogression by a party committed to progression, you comment? Not for a minute—there was no partisanship in

it. Republican, Progressive and Democrat alike joined forces in accomplishing these acts, and by reason of what? By reason of the neglect of the profession in not appreciating the influence of the League of Medical Freedom—by reason of our neglect in not securing pledges from the individual candidates prior to election—by reason of our apathy in not securing petitions and protests against the passage of such laws—by reason of the lack of support of our medical representatives by our personal presence during the session. The physicians who were members of both houses were valiant and undiscouraged fighters, as their opponents can testify, even under the heaviest of odds against old seasoned members and skilled parliamentarians. Various lay friends were loyal adherents.

But in spite of all there is no question that ground was lost, and the profession itself is at fault for its lack of preparation. The political 'spell-binders' and 'stump-spielers' told us during the campaign that this is a progressive age, and each party tried to surpass all others in promises for the good of the whole people. Were you one who tested their sincerity? Did you ask your candidate for the legislature how he stood on matters of public health and medical legislation? Did you inform him that your influence on election day depended on his attitude in these matters? Or did you sit still in your office, and let the opposition cinch him, and then howl after the legislature adjourned because he helped to pass laws detrimental to your interests and the public good?

The chiropractic bill passed both houses by big majorities. It is perfectly natural to look for a scape-goat, but it is a matter of deep regret on the part of those who know, that the present Governor should be the subject of recrimination, in his failure to veto the Bill. The matter has been argued pro and con in the pages of the Journal, and any statement of the writer will perhaps have little weight because he will be accused of partisanship. But in spite of that, and as one man to another, he believes the Governor acted as any other man would have done under similar conditions. It must be remembered that a Governor of a state is the executive of the whole state, and not for any one particular class or profession. It is evident to those who have studied the situation that the public wanted the Chiropractic Board or at least could see no valid objections to it. The laymen cannot be expected to see through our glasses, and after all it is the public who suffer and not the profession. The Governor had telegrams half a foot high on his desk urging him to sign the bill. Petitions signed by thousands of names requested it—one county alone was

prepared with 29,000 signatures. And yet there were less than a dozen physicians in the state who protested against it. What would you a laymen, have done? In the face of all those telegrams and petitions, it is doubtful if any of us would have had the nerve to refuse to sign it, even though we were not in sympathy with it.

Furthermore, the Governor throughout the whole session proved himself a loyal friend to the profession. It was largely his influence which saved for us the Board of Health and its appropriations, the School of Medicine and its appropriation, and the State Tuberculosis Sanatorium. If these do not offset his refusal, which was unavoidable and to be expected, to interfere with the Chiropractic Bill, then it is to be feared that we as a profession are ungrateful to the extreme, and are shutting our eyes to our own shortcomings.

This digression calls for an apology, and the writer offers it, for the subject may have no place in such a program. But in view of what has already been published in our official Journal, it does not seem an inopportune time to submit it to frank and impartial discussion. If we as a profession are to blame, let us realize and correct the fault. To those who urge that we have organization, it is to be said that we have not. It is not enough to get together occasionally and pass resolutions—it is not enough to elect a set of officers and adjourn with the expectation that they can settle all our difficulties. Neither can there be any criticism of these officers, for they have loyally spent time, money and energy in the performance of duties heaped upon them.

Leaders and officers we have in plenty, but we need privates; men who are willing to respond on instant to call; men who are willing to sacrifice a few hours from scientific work to do active political work; men who are willing to forget all other friendships, prejudices and political affiliations to achieve the one end in view, viz., the furtherance of all legislation in favor of public health and welfare and the interests of the profession. We need, to transform an awkward football squad into a flying wedge that will clear the field of all obstacles.

This can be done by still closer organization and more frequent meetings of component county societies, more field men to visit them and exchange views, more practical discussions of opportune subjects, and more instant response of individuals to do active locality work. We need in times of campaign a thoroughly organized central bureau, apart from our regular officers, for they have enough to do with their routine duties, who will knit the

various units into one, arouse enthusiasm, and keep every member of this body in thorough touch with platforms and with men who propose to make our laws. A central campaign committee is essential to the success of any organization, and it must be organized early to be effective. Select candidates who are right before the primary, and sift them out again before the fall election. Fight fire with fire and fight the League of Medical Freedom with its own weapon—the petition and the distribution of literature which will disabuse the minds of the public of their rank fallacies. No man can do more effective campaign work than the physician, for he is the confidante in the home, the man from whom a word of advice falls at the time when it is most easily accepted and absorbed. Don't contribute your mite to the campaign fund and think your duty is ended; your personal influence is what does the business and the profession must have it.

To those who have been stung by the ridicule of our political efforts which has been going the rounds of the lay press, and who argue in a spirit of pessimism that the physician fares best out of politics, is to be commended that story of the Nation's first admiral, John Paul Jones, who on the deck of a sinking ship was commanded to surrender, returned the reply "I have just begun to fight." May be he didn't say it, but anyhow the sentiment is worth while, and none of us can afford to be mere camp-followers while a few faithful ones at the front of battle keep up the fight.

We have not lost as much as we think, and every attack on us only emphasizes to the public our efforts in their behalf. Medical laws and medical men are mere incidents in the march of progress. The public in the end selects what is best from all the schools and profits by it, while schools and cults live and die in accordance with the inevitable natural law of the survival of the fittest.

The writer is an optimist. He believes in the ultimate good. Right and common sense always prevail, and present day medicine is applied common sense. It teaches the prevention of disease, the conservation of life and health, and will in the end receive, and that shortly if our energies are directed properly, the mead of praise to which it is entitled, for its adherence to its ideals.

—o—

THE MEDICAL MAN IN THE LEGISLATURE.

J. S. CUMMINGS, M. D., Bronson, Kansas.

Read before the Kansas Medical Society, May 8, 1913.

The recent Kansas legislature probably differed but little

from former bodies of that kind. Almost all professions and businesses being represented; farmers predominating. There were not so many lawyers in the last legislature as is usually found in such a body. There were three physicians, and in discussing the subject assigned me, when I use the pronouns "I" or "we," I really mean three of us.

We were surprised to find such a large per cent of really bright and able men composing the lower house. All but probably four or five were men of ability, and as to moral uprightness there were but few exceptions to the standard of righteousness in a moral and political sense. If there were any members guilty of selling his vote, as we so often hear spoken of regarding law making bodies, we never heard of it. We take it that each member, to at least some extent, represented the sentiments and opinions of the people of the locality he represented. We, as best we could, championed the interests of hygiene, and public health and pure food and drugs legislation, and in so doing we had some experience and learned a few things.

One thing we learned was that the average legislator does not take much interest in some things that are so dear to the heart of every well-educated medical man. We would divide the legislature into three classes, a few who are warm friends of public health measures—a few who are thoroughly opposed to all public health laws, and a greater number who take no interest in the matter either way. While it was the second class we were compelled to fight, it was the third class that gave us the most grief.

From what we learned during the session of the legislature, and some things we have since learned, every member who fought public health measures had some good reason for the stand he took, either by having had to in some way suffer inconvenience on account of pure food regulations or had had a relative or friend pinched for law violation. In our fights on the floor of the House, in the interest of public health and pure food and drugs, we medical men had the attention and respect of a great majority of the members and we won every point for which we earnestly contended but one.

Many of the legislators as well as a large part of the public, seem to think every move of the members of the medical profession for the public welfare is a selfish move and is some scheme to enrich the medical man at the expense of the public. We will consider some of the reasons for this wide spread impression:

The matter of public health and pure food and drugs has made wonderful advancement during the last ten or fifteen years, and the better the laws enacted for the protection of the public the

more it creates opposition from certain sources. The patent medicine interests are naturally opposed to pure drug legislation, and the different drugless healing cults are opposed to all laws regulating the practice of the healing art. Hence, we have the unusual condition of opposite interests uniting to fight in a common cause.

The drugless healers unite with the patent medicine men against public health matters while the drugless healer condemns all drugs and the patent medicine man depends on the free and useless use of medicine for his success. These combined interests, hope by discrediting the medical man to advance their own interests.

The average physician will, by a reasonable amount of urging, pay three dollars a year to keep in good standing in his County and State Medical Society and thinks it almost a useless expense. On the other hand I have in mind one town in our state where three drugless healers pay a local paper six hundred dollars a year for advertising their business and success. I would not suggest that we advertise in the papers to overcome this influence, but our experience has taught us, that if we want to retain the respect of the people as we should we must adopt a few rules. The medical men should maintain a fair and intelligent lobby at each session of the legislature. We should talk freely with laymen on matters of public health and hygiene.

The physician should respond to invitations to address high schools, clubs, brotherhoods and other organizations on matters of public health and inform them as to the class of men who favor public health and pure food and drug laws. Physicians should take more interest in politics. He could at least talk to candidates for legislative offices and urge support of fair public health measures. The writer has made probably twenty addresses along the line of public health and hygiene during the last two years at and near his home. For that reason and others, maybe for many others, a man who would fight public health measures in that community would meet a cool reception. We surely feel that we should have more medical men in our legislature.

We realize that none of us can render that kind of service to our state without suffering a pecuniary loss and many things he has to do are thankless jobs, but the sense of duty fairly well performed is no mean reward.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,

EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas and appears the first of every month. Correspondence should be addressed to the editor, Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President, M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

One should not overlook the fact when discussing the prevention of blindness that wood alcohol (methyl alcohol) has produced many such cases. A case recently came to the attention of your editor in which blindness was caused by the ingestion of four ounces of wood alcohol. The patient a young man (barely past 20 years of life) was the victim. He had taken two or three drinks of whiskey and being unable to obtain more, procured the wood alcohol with the result of total optic atrophy and consequent blindness.

This is only one of many cases that have been reported and brings to mind forcibly the need for a law absolutely preventing its sale. Denatured alcohol is just as cheap, useful, and far safer. If wood alcohol must be used then it should be made so unpalatable that its drinking would be impossible.

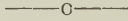
—o—

Another example of the newspaper effect upon suicide can be found in the frequent announcement "Suicide with Bichloride of Mercury", which adorns conspicuously the columns of the daily press. There is not the slightest doubt but that the epidemic of bichloride suicides has been caused by the wide publication of the case of the Georgia banker who died from accidentally taking Ber-

nay's antiseptic tablets thinking they were aspirin. His case was given wide publicity and on account of his supposed painless death many despondents have taken this means to "shuffle off" in this violent manner.

Bichloride tablets, so easy to procure will doubtless end the life of many others.

Truly the newspapers which do so much good in some ways will have a great deal to answer for in others.



PAID LOBBY REJECTED.

One of the most important actions of the House of Delegates was the rejection of the Murphy-Evans idea of maintaining a paid lobby in Washington to promote public health legislation and particularly an Owen bill; one cannot say the Owen bill because there have been such a variety of Owen bills and there is every reason to believe that there will be more. Nothing that has happened to the Association in some years has hurt it so much, in the eyes of the public as the activity of a former representative of the Association in Washington in the winter of 1909-10, in endeavoring to influence legislation in favor of the then Owen bill. It was a lobby and was classed by all laymen in the same class with any other lobby and the general impression was that there must be "something in it" for the Association if they were willing to spend this money to keep a lobby in Washington. This action of the House of Delegates absolutely endorses the policy of the Board of Trustees which was formulated in 1910 when a resolution was introduced instructing our representative to leave Washington; the resolution failed of passage of one vote, but the policy was adopted and the wisdom of it has now been made clear. The whole thing is buried in the minutes of the meeting, but in brief it may be stated as follows: Murphy as Chairman and Evans as Secretary of a Committee on National Health Legislation (a committee that had been abolished by the House of Delegates but was kept alive through a trick) presented an alleged "report" of the committee of nine; the "report" was signed by only four of the nine and only two of these four actually signed their own names to it, the other two being initialed "W. A. E." This "report" demanded the keeping of a lobby in Washington, abused the Trustees unmercifully for not appropriating money during the past two years for that purpose, and generally attacked the Board for its policy of education rather than lobbying. The allegations in the "report" were carefully considered by a reference committee and the report of the reference committee, which report endorsed the policy of the Trustees, deplored the lobby idea and recommended that the Murphy-Evans committee be discharged, was adopted practically unanimously; there were but two or three dissenting votes that could be heard.—California State Journal of Medicine.

Kansas can say amen to the above from the experience with the last legislature.

There is no word spoken against the representatives of the society who officiated in that capacity at the last session, for no matter who would have performed those services, it probably would have resulted in the same condition of affairs.

If there is any lobbying to be done in the future, as has been said before it should be done with the individual legislators and that before the election has conferred upon them "their degree."

MALPRACTICE.

It will be seen from the following note taken from the Journal of the Indiana State Medical Association for February, 1913, that we are not alone in trouble from malpractice suits. When the Indiana State Medical Association adopted the protective feature and made an appropriation of 75 cents per member, to create a fund for its support, we intimated that from our experience the fund would not accumulate very fast. We are now wondering if \$2.00 per member will be sufficient.

"Malpractice suits seem to be on the gain in Indiana if we may judge by the number of applications for medical defense that are coming in to the Committee on Medical Defense of the Indiana State Medical Association. Careful examination of the evidence submitted seems to indicate that the public is advancing more rapidly than some members of the medical profession in a knowledge of what constitutes the best and most scientific methods of treatment. It is also quite evident that some men in the medical profession are attempting work for which they are not fitted by education or experience. It has been quite well said by one of our leading educators that what we need in the medical profession is men with better training and a higher appreciation of ethical and moral obligations."—Journal of Iowa State Medical Society.

Kansas has also made a material gain in mal-practice suits with a consequent increase in the expense of this department. This fact remains, that the medical defense is one of the most important features of the society and one which must be kept going. Proper funds must be provided. No other society in the Union has provided medical defense for its members as cheaply and effectively as has Kansas. We must not curtail the work in this department.

—o—

EDITORIAL CLIPPINGS.

"Chiropractic" Modesty—Some people are really so terribly modest that it is a mystery how they can live, or even be willing to live, in a world so filled with pushing braggarts, and rampant commercialism. For example, note the modest list of things that E. R. Blanchard, D. C., (graduate chiropractor) intimates that he can cure: "Adhesionis, anemia, asthma, appendicitis, blood poison, bronchitis, backache, biliousness, catarrh, constipation, chills and fever, diabetes, dropsy, dizziness, drug and liquor habits, diarrhoea, deafness, eczema, eye diseases, female diseases, gallstones, gravel, goitre, hay fever, headache, indigestion, lumbago, locomotor ataxia, malaria, nervousness, neuralgia, paralysis, piles, pneumonia, rickets, ruptures, rheumatism, St. Vitus' dance, suppressed or painful menstruation, scrofula, tumors, worms, bed wetting and other child's diseases, leucorrhoea or whites, strictures, emissions, impotence and many other diseases." This is almost as long a list as that compiled by the wealthy and admired Law brothers in connection with that they say they can

cure with the wonderful Viavi, that prize of all fakes!—California State Journal of Medicine.

—o—

Where McCabe is Now—The public generally will have no difficulty in recalling the Hon. George P. McCabe. He was that official of the Department of Agriculture under the Taft Wilson regime whose steady hostility to the enforcement of the Pure Food Law, aided by a discreditable conspiracy which he engineered, finally forced Dr. Wiley out, Mr. McCabe is now ready to capitalize his experience. This circular letter, sent out from his office, tells its own story.

GEO. P. McCABE
Attorney-at-Law
410-11-12 Lewis Building,
Portland, Oregon.

Gentlemen—You are interested in the application of the food and drugs laws, national and state, to the labeling and composition of the products which you sell.

Court cases, with attendant public notice of violation, are expensive and hurtful. These can be avoided. It is a case where an ounce of prevention is worth a pound of cure.

For that reason I desire to call your attention to the fact that I have opened a law office in Portland, and am prepared to advise manufacturers and dealers on the legality of their labels, and if necessary to represent them before the United States Bureau of Chemistry laboratories, the various State Food Commissioners, and the state and federal courts.

For the past several years and until the third day of March of this year, when I resigned, I have been Solicitor of the United States Department of Agriculture, and until recently a member of the United States Board of Food and Drug Inspection. In those positions I was in charge of all prosecutions under the national act, and became thoroughly familiar with the food laws and regulations of the states.

I am under retainers now from a number of manufacturers as adviser on food and drug matters. If you feel the necessity of advice on these subjects, let me hear from you. Very truly yours,

(Signed) GEO. P. McCABE.
—Collier's Weekly.

—o—

The Poison Label—A Needed Amendment—For the purpose of safeguarding the public against the dangers of poisons, Mr. French

of Idaho has introduced into the House of Representatives a proposed amendment to the federal Food and Drugs Act. The amendment which refers to labels and containers of poisons declare that a drug shall be deemed misbranded:

"If the contents of the package be a virulent poison and shall not be placed in a container labeled 'Poison' and shall not contain on the label at least one suitable antidote and the name of the person, firm or corporation dispensing the substance, and in the case of liquids, in addition thereto, said container shall be a colored glass roughened bottle of a type described by Secretary of the Treasury, the Secretary of Agriculture and the Secretary of Commerce."

Idaho is to be congratulated on having a representative whose solicitude for the public safety may be the means of strengthening the Food and Drugs Act. "In the past," says the Journal of the American Medical Association, "it has been altogether too easy for careless or unscrupulous manufacturers to sell powerful drugs without giving the purchaser any hint as to the potency of the product he was buying. Another amendment should be made, or the proposed one modified, so as to protect the public still further. All 'patent medicines' containing poisonous drugs should be required to be labeled 'Poison.' The protective action of such an amendment would soon be demonstrated. In Great Britain, where there is such a legal requirement, preparations like Winslow's Soothing Syrup, containing such insidious poisons as morphin, have to be labeled 'Poison.' As a result the Winslow concern has taken the morphin out of its British product and has substituted a drug that is not listed in the schedule of poisons. But Winslows' Soothing Syrup still goes to American babies with its deadly morphin. The value of the requirement lies in the fact that the word 'Poison' has a very real and definite meaning to any person that reads English. The same cannot be said of the chemical names for various poisons. Thus the most ignorant of mothers would hesitate to give her child a 'patent medicine' that was labeled 'Poison', but she would pay little attention to the statement that it contained morphin, for instance. The weakness of the present federal law has been referred to many times. As the law now stands, 'patent medicines' may go to the public containing such deadly poisons as strychnin, atropin, prussic acid, arsenic, etc., with no warnings or hint of the presence of these drugs."

SOCIETY NOTES.

Medical Association of the Southwest—Kansas City will entertain this society on October 7-8, 1913, Dr. W. T. Wootton of Hot Springs, president. Dr. J. A. Witherspoon, president A. M. A., will deliver an evening address. Sessions will be held at the Coates House, which will also be headquarters. Clinics will be held in the hospitals before and following the meeting. A cordial welcome extended to visiting physicians.

—o—

The Coming Clinical Congress—The Clinical Congress of Surgeons of North America will hold its fourth annual session in Chicago, November 10-15. A complete program of clinics is to be held on each day from 8 a. m. to 5 p. m., covering every branch in surgery. The general headquarters of the Congress will be at the Hotel La Salle, where the eighteenth and nineteenth floors have been reserved for registration room, bulletin rooms, etc. The headquarters of the section on surgery of the eye, ear, nose and throat will be at the Hotel Sherman and at each of these headquarters the daily clinical program will be bulletined one day in advance. On each evening of the week except Saturday, there will be scientific sessions, and on Tuesday, Thursday and Friday evenings, special meetings will be held for those interested in surgery of the eye, ear, nose throat and mouth. Dr. E. Wyllys Andrews is chairman of the committee on arrangements and Dr. Franklin H. Martin general secretary of the Congress.

—o—

At a recent meeting of the McPherson physicians, a county society was organized. Dr. L. A. Bradburg of Galva was elected president and Dr. G. R. Dean of McPherson, secretary.

—o—

Atchison county recently re-organized at Atchison and elected Dr. M. T. Dingess president and Dr. E. T. Shelly secretary, both of Atchison.

—o—

NEWS NOTES

Dr. G. Meyer has moved from Linconville to Abilene.

—o—

Dr. J. C. Lardner has moved from Bronson to Fort Scott.

—o—

Dr. U. G. Hoshan has moved from Chanute to Joplin, Mo. His practice will be limited to diseases of women.

Dr. W. L. Carlyle has moved from Hanover to Sabetha.

—o—

Dr. Theodore Kroesch has moved from Frederick to Enterprise.

—o—

Dr. J. D. Riddell has moved from Enterprise to Salina.

—o—

Dr. W. L. Borst has moved from Topeka to Meriden.

—o—

Dr. C. M. Stemen of Kansas City, Kansas, has returned from a months' trip to New York.

—o—

Dr. Sebree S. McGinnis of Tribune, Kansas, was married June 24th to Miss Abby Baker of Pueblo, Colorado.

—o—

The Northeast Kansas Medical Society will meet at Leavenworth, September 25th. REMEMBER THE DATE.

—o—

Dr. W. D. Moore has moved from Eudora to Salt Lake City, Utah.

—o—

Dr. J. E. Sawtell was recently appointed a member of the Board of Medical Examination and Registration. He succeeds Dr. F. A. Carmichael.

—o—

For Sale—Bryant and Buck's American Practice of Surgery. Almost new. Sheep binding. Price \$45.00, delivered within 100 miles.—James R. Smithheiser, M. D., Westphalia, Kansas.

—o—

Dr. F. A. Carmichael of Goodland, who was appointed superintendent of the Osawatimie Asylum by Governor Hodges recently assumed charge. Dr. S. L. Brooking of Paola, has also taken up his duties as assistant at the institution.

—o—

Dr. L. L. Uhls recently resigned as superintendent of the State Asylum at Osawatimie, after having served in that capacity for many years.

Dr. Uhls has opened a sanitarium for the treatment of nervous and mental diseases at Overland Park a suburb of Kansas City.

—o—

Dr. J. R. Ernest of Kansas City, Kansas, has been appointed surgeon in the United States Coast and Geodetic Survey Service. Doctor Ernest was recently house surgeon at Bethany Hospital.

He left August 14th for Washington to enter upon his duties at once. The position was obtained by a civil service examination.

—o—

OBITUARY.

Orville L. Helwig, M. D., Kansas City Medical College, Kansas City, Mo., 1896; slipped and fell in a bathroom in his hospital in Garden City, Kan., June 22, sustaining injuries from which he died a few hours later, aged 44.

—o—

Adam Rupin, M. D., Homeopathic Medical College of Missouri, St. Louis, 1878; died at his home in Topeka, Kans., July 1, from cerebral hemorrhage, aged 75.

—o—

Joseph Ingels, M. D., College of Physicians and Surgeons, Keokuk, Iowa, 1878; a member of the Kansas Medical Society; for thirty-nine years a practitioner of Pawnee County; died at his home in Larned, July 27, from cerebral hemorrhage, aged 64.

—o—

William Die McPhee, M. D., Kansas Medical College, Topeka, 1898; of Anthony, Kans., coroner of Harper County in 1904 and county health officer in 1905-1906; local surgeon of the Rock Island System; aged 42, while suffering from melancholia, hung himself at the home of his parents in Anthony, June 8.

—c—

REVIEWS.

The Tendency to Fads—A tendency in this country to taking up fads of all kinds as shown in its medical history, is remarked by Joseph Zeisler, Chicago (Journal A. M. A., August 9). To mention, he says, the more noteworthy fads relating to medicine in different times, he cites the practice of orchidectomy a few years ago and later the Bottini operation, the sacrifice of the ovaries at one time, the prevalence of appendectomy at present, the fad of nerve stretching and the injection of paraffin for cosmetic purposes, and expresses his opinion that the extent to which Freud's psychanalysis has been exploited in neurologic literature also borders on faddism. Coming to fads more interesting to dermatologists, he refers to the too indiscriminate use of the x-ray and the changing fashions in the treatment of syphilis. He feels like severely criticizing one phase of the most modern treatment of lues—the exposure by surgery of the vein into which salvarsan is to be injected. Recent over-exploitation of vaccine treatment and the

stress which is laid on anaphylaxis as a cause of skin disease is also included among the fads. One of the greatest results of modern serologic studies is the so-called Wassermann test, the value of which is fully established in the diagnosis of syphilis; but he also thinks this excellent method is also being abused and made a fad of as a sort of diagnostic *pons asinorum* in non-specific diseases. The pathologic laboratory should not be used in the pursuit of fads. Clinical knowledge is in danger of being neglected in its favor and the two must work together if we are to do our best work.

— — — — —

Extra-Uterine Pregnancy—Dr. Farrar Cobb of Boston has made a careful study of 137 cases of tubal pregnancy at Massachusetts General Hospital, with the view of giving information as to the wisdom of immediate operation in desperate cases of hemorrhage and arrives at the following conclusions:

1. More than 33 per cent of extra-uterine pregnancies occur in young women who have never before been pregnant.

2. Salpingitis, or pelvic infection, is not an essential or frequent causative factor.

3. Most of the cases of complete rupture with alarming hemorrhage occur in the early weeks, often in the first month; these are the causes that are rapidly fatal unless operated on. Cases that have gone two months or more are those that furnish the greatest number of non-emergency cases.

4. Cases of sudden, severe rupture, until signs of marked intra-abdominal hemorrhage are present, often simulate other grave abdominal emergencies with signs of extreme hemorrhage, operation should be done at once without waiting for a possible reaction.

6. In the less severe cases of tubal rupture, without signs of marked hemorrhage, a correct diagnosis is often difficult or impossible.

7. The menstrual history cannot be depended upon; many of the most alarming cases had skipped no period.

8. The character and location of the pain may vary within wide limits.

9. Tubal abortions are nearly as frequent as tubal ruptures. Cases of tubal abortion seldom give a history of skipping a menstrual period, but a history of continued slight flowing or dribbling since the last period.—Journal Iowa State Medical Society.

MISCELLANEOUS.

Professional Men as Candidates for the Sucker List—How do these gold brick peddlers know that you are one of that species, a representative of which is born every minute?

This pointed question is asked by John Oskinson, financial editor of Collier's Weekly, writing in the Chicago Tribune. He answers his question thus:

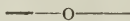
No sucker fisherman could afford to go on the theory that all are possible suckers and send his bait around indiscriminately. It would cost too much. So to qualify as a real grown-up sucker you must get on a sucker list.

If you are a teacher, a preacher or a doctor you are pretty sure to be tested by some one of the fishermen. After you bite once you are passed along—you become an asset to the whole trike. Your name is worth anywhere from 10 cents to \$10, depending on how readily you bite and the amount of money you have dropped into the pockets of the promoters who have had their chance at you.

The teacher, the doctor and the preacher are ideal suckers, says Mr. Oskinson; their earnings are usually small, their families large and their sense of duty highly developed. Perhaps you would conclude, therefore, that they ought to be the very ones to keep away from the bait. No; they see the cost of everything which represents a decent existence rising higher and higher, while their income mounts with exceeding slowness or not at all. They will save something—at any cost of self-deprivation. And when that saving amounts to a hundred dollars or more they become susceptible.

Many are so ignorant of business that when they read the sunrise-tinted literature of promoters they actually believe they have a fair chance to obtain 100 per cent in a short time on their investment. Government figures show that last year 525,000 persons lost \$120,000,000 to persons indicted for fraudulent use of the mails.

Mr. Oskinson concluded that the only sure way to avoid being caught as a sucker is to stick close to the side of the bank or banker whose business is under the supervision of a state or national government.—West Virginia Medical Journal.



CLINICAL NOTES

Peritonitis from Rupturing Pus Tube—Every case of pus tubes or parametric abscess, regardless of its duration, should be treated

as a case known to contain organisms capable of producing peritonitis in the event of rupture. It is by such a course only that the risk of infection is reduced to the minimum.—F. D. Smythe, in the *Southern Medical Journal*.

— a —

Perinephritic Abscess—Cases of perinephritic abscess are not rare and successful treatment depends on early recognition and early incision, thus evacuating the pus before it has had time to burrow extensively.

The chief symptoms which should aid in the diagnosis are, first, the history; second, urine analysis; third, the range of pulse and temperature; fourth, the leucocytic count; fifth, and most important, the ever-present point of tenderness between the internal oblique, the 12th rib, and the erector spinæ muscles.—E. C. Robitshek in *The Journal-Lancet*.

— o —

A Sign in Acute Appendicitis—In October, 1912, I began to notice a marked state of congestion of the right superficial circumflex iliac vein in cases of acute appendicitis.

At first I thought this might be merely a coincidence, but its regular appearance when I was on the outlook for it makes that extremely unlikely; in fact, I have never failed to find it in my own cases, and the senior house surgeon at our infirmary reports that he has always seen it in the cases coming under the care of my colleagues. Therefore I think it must be nearly always present and distinguishable.—John Blair in *The British Medical Journal*.

— o —

Treatment of Empyema—1. Empyema of infancy has a high mortality under any method of treatment yet proposed.

2. One of the chief obstacles to recovery is the difficulty in expansion when the lung is subjected to atmospheric pressure. This rather than imperfect drainage is the principal factor in causing the present high mortality.

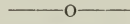
3. Aspiration, while occasionally sufficient to cure a localized empyema, is not to be depended on as a means of treatment.

4. The injection of bactericidal substances is not greatly superior to simple aspiration, and is open to the same dangers.

5. Rib resection is not to be advised in recent acute cases in patients under two years old. In chronic cases it may be necessary at any age.

6. Simple incision between the ribs with the introduction of a single tube is sufficient in most cases to secure adequate drainage. It accomplishes in recent cases all that rib resection can do with less disturbance to the patient.

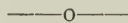
7. Siphon drainage is to be preferred to any other treatment in infants, especially those under one year, giving not only proper drainage and facilitating expansion of the lung, but causing the least disturbance of the patients during the treatment and showing the highest proportion of recoveries.—Holt, *American Medicine*.



The Treatment of Metatarsalgia—Morton's disease or metatarsalgia, is a not infrequent orthopoeedic condition, met with in general practice, characterized by more or less acute cramp-like pains occurring at the base of the third or fourth toes. The pain comes on suddenly during the use of the foot and may be very severe. It is often accompanied by a snapping of the bones. A sense of soreness or numbness remains after the attack is over. The etiological factor seems to be a mechanical one; the lateral pressure of the head of one metatarsal bone below and against the neck of the neighboring metatarsal bone results in an undue pressure upon the superficial branch of the external nerve and its digital branches, which are squeezed between the two bones.

Attempts have been frequently made to alleviate the condition by correcting the flat-foot, which not infrequently is, associated with the metatarsalgia, and also by fitting a metal plate with a gradual dome raised to fit in behind the head of one of the offending metatarsal bones. More rarely a division of the superficial branch of the external plantar nerve or the resection of one of the heads of the metatarsal bones has been employed to relieve an obstinate case.

T. P. Low (*Brit. Med. Jour.*, March 15, 1913), treats metatarsalgia by grasping the affected foot with the hands, one on either side, and forcibly moving the metatarsal bones upon each other, and then forcibly flexing and extending the toes and foot. In this way any existing adhesions may be broken up. Low claims that in the few cases in which he has tried this simple form of treatment, all have responded well the relief has been permanent. Shoes of proper width should be worn after an attack to avoid compression on the front of the foot.—*Medical Review of Reviews*.



There are two types of sarcoma common in the lower part of the thigh or at the knee which do not call for amputation of the limb; one grows from the fascia or periosteum, and one from the bone—the fibrosarcoma, and the myeloid or giant-celled sarcoma.—Bernay's *Golden Rules of Surgery*.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, OCT. 1913.

No. 10.

THE FEEBLE-MINDED AS REVEALED BY THE BINET-SIMON MEASURING SCALE FOR INTELLIGENCE.

DR. E. E. LIGGETT, Oswego, Kansas.

Read before the Southeast Kansas Medical Society April 3, 1913.

Any one who has had much to do with children must have noticed how rapid is their mental development, and what wonderful changes this mental development brings to them. It is not that the child learns new facts quickly, for in truth it does not. The brightest pupil in our schools can not learn new things as readily as a well-trained adult. But the child learning new facts takes on new powers, becomes a new creature; while the adult remains the same old person.

This is illustrated by showing a certain picture to a child three years old and asking him what he sees. He will say he sees some men; some boards; a saw; some nails; an ax and a house. At seven years he will say he sees a man sawing a board; another chopping; and another driving nails in a house. At fifteen years he will say he sees some men building a house. The child at three years sees the objects, the concrete things, as well as he ever will. At seven years he sees the doing, the action; but the youth of fifteen sees the purpose of the action, and beyond this he will never go. Again, a child at five years can copy the figure of a square but not a diamond; that comes two years later, when it is seven years old. If the child is less than eleven, you can tell him that you have locked yourself in your room and cannot get out because you left the key on the outside, and he will believe you. At fourteen years, given the position of the hands on the face of a clock, any proper child can tell you what time would be indicated if the hands were reversed. These and other tests, definitely show stages in the mental growth of children; and the presence of these stages is the fundamental idea in the Binet-Simon scale for measuring intelligence.

The French psychologist, Binet, has worked out a series of tests so standardized, that they show with wonderful exactness inherent mental qualities. By their use it is possible to tell not only what a child is, but what it is probable that he will do. As an example: if I were to say 2-4-9-5-8-3-7, all those who hear me today could repeat the series at once without an error, although the series would be forgotten in a half a minute. If I were to recite a series of eight figures, or names, almost if not all of my hearers, together with all other bright people, could repeat them as in the series of seven numerals. It is a pretty smart individual who can carry nine; and I would like to have the income anyone who can carry ten or more, can command. The great majority of mankind can carry seven, as can also the youth of twelve years. At ten years the child breaks down on seven but can carry six. At eight years he can carry five; at five years he carries three, and at three years he can repeat two. All this is independent of any training or learning by rote. It is altogether different from a school examination, which is a test of what a child has been taught, or rather of what he knows. These are tests of attention; tests of the grip of the memory; tests of the quality of the very protoplasm of the brain. Moreover, they are as definite and exact in their results as the stretch of the hand over the piano keys is a measure of its size and suppleness.

It has been determined that the very brightest minds attain their maximum of development, and slow down and stiffen into fixity at or before forty. The average professional mind stops at about twenty; while the great mass of mankind stop mental growth at from fifteen to twenty. This does not mean that we cannot learn new facts or do new work after that time, but the learning these new facts does not give us new powers; does not make a new creature of us as before, but we remain the same old person.

The Binet tests enables us to measure the mental age of persons under fifteen years of age with as much exactness as we are able to match colors on a color scale. Now if a child is found to be lagging one, or even two years behind his birthdays, he may, by special training and special care, be enabled to catch up. He may be a little slow, but he is recognized as normal and can get along. The mind that slows down and stops at thirteen is barely able to make a living and care for itself through life; but since it is able to care for itself it is recognized as normal, being only two years behind. But if found to be three years behind, he is feeble-minded, due to inherent defect, and he can never be normal.

The feeble-minded group is divided into three classes, namely:

the idiots, the imbeciles and the newly recognized type of feeble-minded, the morons. The idiot's mind has stopped growing at or before three years. The imbecile's mind has stopped after three years, but before eight years; while the moron's mind has grown past eight years, but has stopped before thirteen years. Each of these classes is again subdivided into three groups called the low grade, the middle grade and the high grade. Or in other words we have the low grade idiot, the middle grade idiot and the high grade idiot. Then the low grade imbecile, the middle grade imbecile, and the high grade imbecile. The low grade moron, the middle grade moron, and the high grade moron. Although it has not been done, so far as we can learn, this subdivision might well be carried on into the normal; and we would have the low grade normal, the middle grade normal and the high grade normal. The line between the high grade feeble-minded moron and the low grade normal, has been so indistinct and so ill-defined that the problem of separating these two classes has heretofore been approached with timidity, or shirked in many instances. The psychologist has been inclined to place the line too high; including in his list many persons that were able to take care of themselves, though in a rather poor manner. On the other hand the courts, the governmental machinery, and the great mass of mankind were prone to put the line too low; and many dependent men and women who are really only little boys and girls of eight or ten years old, are held responsible and often severely punished, because they do not conform to the social and industrial requirements of a community of grown up normal men and women. It would seem that it is less repugnant to the feelings of a majority of normal mankind to consider their less fortunate fellows as vicious and immoral, rather than defective and feeble-minded.

The idiot whose mental growth stopped before he was three years old, is easily recognized by most observers. They are the helpless, sprawling, dirty, bestial creatures we have seen or known in some unfortunate family or in some state institution. Their very helplessness robs them of much power for harm and they live their lives without reproduction and pass on. These and the imbeciles of all grades, are much alike in being a source of anxiety and distress to their immediate friends, and oftentimes a charge on the state; but their mental deficiency has so distorted or marked their physical bodies that they are easily recognized and so cared for. The imbeciles and the low grade morons make up that pitiable class that go about communities known as "Simple Simon" or "Crazy Jane" or some such familiar term. They are a constant

menace to our welfare to be sure, but we are all able to recognize them and so in a good measure guard ourselves against them. But the high grade moron is a very different proposition and his problem is very much more difficult.

One difficulty in a proper understanding of feeble-mindedness is our preconceived notion that the idiots and the imbeciles solely comprise the feeble-minded class. We all know people who do not get along well. People who do things that make us call them "fools," forgetting that this very thing means irresponsibility. People who cannot do anything well; who cannot be trusted to do a days work of even the simplest manual labor undirected or without supervision; people who apparently are not at all able to live in conformity with the laws of society—these people drift along in their helpless way until they become dependents; either dependent paupers in our alms houses or dependent criminals in our jails and penitentiaries; or become a plague in our communities. We have been able to do nothing much for them, or rather we have not recognized that we should do much for them, until they have gotten into that manner of life and living that we do not care to disturb.

By means of the Binet scale of intelligence we are now able to pick these people out while they are yet children and give them the special care and training their defect requires. By special training a child only two years or less behind his birthdays may be enabled to get along as a normal person, although a little slow. But if he is three years behind, he is feeble-minded.

Now a feeble-minded person is not able to compete with the normal in the struggle for existence; he is not able to manage his affairs with prudence. The consequence is that when he gets out in the world he cannot live a normal life. He cannot be allowed to starve; so if he is of a dull nature, he accepts charity and goes to the city or county for support. If he is of a different temperament he takes matters into his own incompetent hands and tries to live by his hands and wits or he steals what he cannot earn. The jail or the penitentiary soon finds another victim. If the person is a female, her natural sex instincts together with her lack of intellect to control makes it almost certain that she will quickly enter a life of prostitution. Statistics on these matters are not full, but such as have been gathered show that at least 30% of the convicted criminal class is feeble-minded; and about 90% of prostitutes and girls over fifteen years of age in houses of correction, are morons, usually of the higher grades. Of alcoholics, over 30% are feeble-minded.

In addition to the heavy burden these criminal and social outcasts are upon society, the morons, whether depraved or not, are an element of danger in any community; having an adult's physical strength they have only a child's judgment to direct it; and like a child they may fly into a rage at any time and do murder or any other crime, not having mental capacity to properly foresee or estimate, the effect of their acts, either upon themselves or others.

To get the picture of the class of defectives we have been trying to describe more vividly before you, let me quote a description of a young man, an inmate of the New Jersey Training School for Feeble-Minded, given by Brewster in McClure's Magazine.

"Here, for example, is a young fellow of twenty, strong, well set up, open faced, altogether a distinctly pleasing personality. He has been working hard all day, breaking up new land, and has come in at night, comfortably weary, gloriously hungry, and ready for bath and supper. Question him about his occupations, interests, companions, and he answers promptly and intelligently. Inquiry shows that he leads the school orchestra, takes part in theatricals, does beautiful work at two handicrafts, and in addition is a crack athlete, quite able to hold his own on track or diamond against most college boys. He looks, in short, like a distinctly promising youth, of whom almost any parent might be proud.

But take him into the laboratory and put him through the Binet tests, and he breaks down at thirteen. He was a likely baby. His mind developed normally during early boyhood. At eight or nine it began to slow down. At twelve it stopped. No matter how long that man lives, he will never be more than twelve years old.

Meanwhile, he will do everything that a child of twelve can do, and do it with a man's strength. He can accomplish almost any sort of routine task—care for stock, lay bricks, work at tailoring, perform any mechanical operation as well as anybody—provided somebody else plans his work. But he cannot plan for himself, and he cannot take responsibility—naturally not, since he is only twelve.

He has had ten years of the most painstaking, as well as the most thoroughly scientific, education to be had anywhere in America—and it hasn't made a particle of difference. He knows more than a child of twelve, because he has had twice as many years to learn it in; but his learning is all on the twelve-year-old level. All the range and grasp and interests of the thirteen-year-old mind are forever to him a closed book.

So long as this man is kept in charge of kindly persons who treat him as the twelve-year-old he really is, not the man he appears to be, and so long as he is given no task beyond those which careful tests show that he can do with ease and pleasure, he is happy, docile, affectionate. But let him out into the grown-up world, and at once he is in six different kinds of trouble. He can not make a living at a man's work, because he is only a little boy; while, on the other hand, nobody will look out for him like a little boy, because everybody takes him for a man. The outside world is not adapted to such as he, and therefore, according to his natural or acquired energy, he drifts into pauperism or crime. With the forethought of his twelve years, he becomes responsible for a family which he can not possibly support. In a panic of childish jealousy or fear, he is as dangerous as a frightened horse. He has all the impulses of a grown man, with a child's power to regulate them. Yet this man is very close to a normal individual."

Here again is another picture of a defective—a girl, this time drawn by Dr. Goddard, Superintendent of the Training School at Vineland N. J. The girl is twenty-two years old and has been in the institution fourteen years.

"She is cheerful, inclined to be quarrelsome, very active and restless, very affectionate, willing, and tries; is quick and excitable, fairly good tempered. Learns a new occupation quickly, but requires a half or twenty-four repetitions to learn four lines. Retains well what she has once learned. Needs close supervision. Is bold towards strangers, kind towards animals. Can run an electric sewing machine, cook, and do practically everything about the house. Has no noticeable defect. She is quick and observing, has a good memory, writes fairly, does excellent work in wood-carving and kindergarten, is excellent in imitation. Is a poor reader and poor at numbers. Does fine basketry and gardening. Spelling is poor; music is excellent; sewing excellent; excellent in entertainment work. Very fond of children and good in helping care for them. Has a good sense of order and cleanliness. Is not always truthful and has been known to steal, although does not have a reputation for this. Is proud of her clothes. Likes pretty dresses and likes to help in other cottages, even to temporarily taking charge of a group."

After showing by the Binet tests that this girl is only a little over nine years old mentally, Dr. Goddard goes on to say, "This is a typical illustration of the mentality of a high grade feeble-minded person, the moron, the delinquent, the kind of a girl or woman that fills our reformatories. They are wayward, they get into all sorts

of trouble and difficulties, sexually and otherwise; and yet we have been accustomed to account for their defects on the basis of viciousness, environment or of ignorance.

It is also the history of the same type of girl in the public school. Rather good looking, bright in appearance, with many attractive ways, the teacher clings to the hope, indeed insists, that such a girl will come out all right. Our work with Deborah convinces us that such hopes are delusions.

Here is a child who has been most carefully guarded. She has been persistently trained since she was eight years old, and yet nothing has been accomplished in the direction of higher intelligence or general education. Today if this young woman were to leave the institution, she would at once become a prey to the designs of evil men or evil women and would lead a life that would be vicious, immoral and criminal, though, because of her mentality, she herself would not be responsible. There is nothing that she might not be led into, because she has no power of control, and all her instincts and appetites are in the direction that would lead to vice." . . . The question is, "How do we account for this kind of individual? The answer is in the word 'Heredity', bad stock."

The burdens on society, and the dangers to individuals, imposed upon the country by the present generation of morous is insignificant as compared to the vastly more important matters of their multiplication, (Tregold says that "Feeble-minded people multiply at twice the rate of normal people") and the yet more important matter of the heredity of their mental defect.

To illustrate what this trait of heredity means to society, I quote again from Dr. Goddard in his recent book "The Kallikak Family,"

"Just before attaining his majority, Martin Kallikak Sr., of good family, joined one of the numerous military companies that were formed to protect the country at the beginning of the Revolution. At one of the taverns frequented by the militia he met a feeble-minded girl, by whom he became the father of a feeble-minded son. This child was given by its mother the name of its father in full, and thus has been handed down to posterity the fathers name and the mother's mental capacity. This illegitimate boy was Martin Kallikak Jr., and from him have come four hundred and eighty descendants. One hundred and forty-three of these we have conclusive proof, were or are, feeble-minded, while only forty-six have been found normal. The rest are unknown or doubtful.

Among these four hundred and eighty descendants, thirty-six have been illegitimate. There have been thirty-three sexually immoral persons, mostly prostitutes. There have been twenty-four confirmed alcoholics. There have been three epileptics. Eighty-two died in infancy. Three were criminals. Eight kept houses of ill fame.

These people have married into other families, generally of the same type, so that now we have on record and charted eleven hundred and forty-six individuals. Of this large group, we have discovered that two hundred and sixty-two are feeble-minded, while one hundred and ninety-seven are considered normal, the remaining five hundred and eighty-one being still undetermined.

Martin Sr., on leaving the Revolutionary Army, straightened up and married a respectable girl of good family, and through that union has come another line of descendants of radically different character. These now number four hundred and ninety-six in direct descent. All of them are normal people. Three men only have been found among them who were somewhat degenerate, but were not defective. Two of these were alcoholic, and the other was sexually loose.

In this family and its collateral branches we find nothing but good citizenship. There are doctors, lawyers, judges, educators, traders, landholders, in short respectable citizens, men and women prominent in every phase of social life. There have been no feeble-minded among them; no illegitimate children; no immoral woman; only one man sexually loose. There has been no epilepsy, no criminals, no keepers of houses of prostitution. Only fifteen children have died in infancy. There has been one "insane," perhaps inherited, but not from the Kallikak side."

The history of these two families, living side by side in a rural community is very strong proof of the hereditary nature of feeble-mindedness and such cases are by no means limited to the Kallikak family in N. J., but many repetitions of them are no doubt all around us. It has been definitely determined that two per cent of school children are feeble-minded; and of course they may be expected to grow up and propagate their kind. The question then remains "What are we to do about it?"

For the purpose of this paper this question may be briefly answered by saying: First, test out the feeble-minded school children and as they come to puberty segregate them into institutions where they may be well cared for and yet be prevented from reproducing their kind. Second, we can if we will, prevent the birth

of feeble-minded children by sterilizing these persons who would become the parents of feeble-minded children.

In closing I want to say that the material, the ideas, and in perhaps too many instances the language of this paper has been gathered from my reading; but I wish to acknowledge particular indebtedness to the article of Mr. Brewster and to the various writings of Dr. Goddard, of the Vineland Training School.

—o—

VERATRUM VIRIDE IN PUERPERAL ECLAMPSIA.

DR. F. M. WILEY, Fredonia, Kansas.

Read before the Kansas Medical Society May 7, 1913.

The use of veratrum viride in the treatment of puerperal eclampsia, is not new. Lusk, in his 1892 edition accredits Dr. Fearn of Brooklyn with first calling the attention of the profession to the use of the drug. In the American Journal of Obstetrics, for May, 1871, Dr. Fearn contributed an article on veratrum viride in large doses, as a substitute for blood-letting in puerperal convulsions.

In this article he recommends the tincture of veratrum in doses varying from 15 minims to a teaspoonful, repeated every five or ten minutes, until the pulse becomes soft, or vomiting sets in. He advises the veratrum to be administered in smaller doses for several hours after the convulsions are arrested, in order to keep the pulse below fifty to the minute. He states that the large doses are devoid of danger so long as the convulsions continue.

At the period when this article appeared, the practice of blood-letting for eclampsia was in favor, and in fact, was almost universally resorted to, and the profession seems to have been deaf to Dr. Fearn's plea for the substitution of veratrum for the sanguinary procedure.

Lusk, after referring to Dr. Fearn's article, states that after carefully watching the cases to the end he was led to conclude that the claims of bleeding in eclampsia rested upon a substantial foundation, and that it formed the first step in the treatment. As late as 1909, in the April meeting of the Mississippi State Medical Society, several prominent physicians advocated bleeding, and the author of a paper on eclampsia condemned veratrum, claiming that it weakens the heart's action, and does not favor elimination.

DeLee, in his monumental work, issued March, 1913, consigns veratrum to oblivion with the statement that, "large experience does not sustain it. In the author's experience the drug has not

altered the result either way, and he seldom uses it, and then only in the puerperium."

On the other hand, during the past twenty five years the Journals have published scores of articles advocating its use and relating the personal experience of the authors in support of it. In the main, these articles have come from physicians practicing in the rural districts, who modestly report from one to a dozen cases treated mainly or wholly with veratrum, with a very low rate of mortality, or none at all.

Edgar gives it a place secondary to chloroform, yet, in his description of the use of veratrum, he ascribes to it virtues and effects far superior to those of chloroform. He states that with the pulse strong as well as rapid, it offers the most certain means at our command for temporarily, and even permanently controlling the spasms.

To Dr. J. R. Willets of Wilson County, Kansas, belongs the honor of discovering the marvelous effects of veratrum in the control of eclampsia. This was in 1874, and Dr. Willets had not seen or heard of Dr. Fearn's paper on the subject, published three years previously. Dr. Willets was a close student of the effects of medicines. The case in which he first used the drug was one in which thirty convulsions had occurred in about twenty-four hours, persistently resisting treatment by bleeding, chloroform, chloral, bromides and morphia. Reasoning from the effects of veratrum in pneumonia and other diseases accompanied by a high blood pressure, Dr. Willets used twenty drops of Norwood's tincture of veratrum viride hyperdermically, and followed it with an equal dose in an hour. The result was a prompt cessation of the convulsions and a gradual recovery from the coma, which had been profound throughout the attack. He afterward used the drug in six additional cases with success. His experience was related in a paper read before the Wilson County Medical Society, and published in the Kansas Medical Journal. The result was a prompt adoption of the treatment by the physicians of Wilson County, with whom it has continued in constant favor until the present time.

Recently, I addressed a circular letter to the members of the Wilson County Medical Society asking for their experience in the use of veratrum in eclampsia; in answers to the following questions:

1. Have you used veratrum in these cases?
2. In how many cases have you used it?
3. Have you depended upon veratrum exclusively, or have you used it with other remedies?
4. What number of cases have proved fatal to the mother?

5. Do you think, from your own experience, that any other single remedy is superior to veratrum?

6. Have you a theory as to the favorable effects of veratrum in eclampsia?

7. What preparation do you use?

Fifteen gentlemen favored me with replies. All had used the remedy in a total of eighty-six cases, not all, however, occurring in Wilson County. Eight physicians report that they have depended upon veratrum exclusively; six have used it with other remedies, mentioning bromide per rectum, chloroform, elaterium, calomel, salines, morphine and tropine, Abbott's H. M. C. Compound, amyl nitrite and immediate delivery; but have placed their main reliance upon veratrum, and ascribe to it the favorable results obtained. One physician reports three cases treated with veratrum in conjunction with other remedies, all of which recovered, though he failed to get the characteristic effects of veratrum. In answer to the fourth question, four deaths are reported, or a mortality rate of four and sixty-five hundredths per cent. Thirteen physicians affirm that they consider no other single remedy superior to veratrum, and six consider veratrum a specific.

The theories of these gentlemen as to the action of veratrum are as varied as the views of the etiology of eclampsia held by the profession in general. While I do not purpose to enter into a discussion of these theories, a mere enumeration of them may be of interest. They include:

1. Reduction of blood pressure—relaxation.
2. Diaphoresis and diuresis—elimination of poison.
3. It acts as a superior systemic antiseptic.
4. It acts as an antispasmodic and equalizer of the circulation.
5. It reduces temperature.
6. It simply holds the patient until proper elimination can be effected.
7. It inhibits the heart's action, thus relieving the congestion of the spinal cord.
8. It stimulates the vagus.

Personally, I have used veratrum in seven cases, all of which recovered. In each of four cases there was but a single convulsion; two patients each had a second convulsion, and one had five before they were brought under control, and a sixth fourteen hours later, after I had left the patient and was depending upon the oral administration of veratrum to control the pulse and the convulsions.

Occasionally a case of eclampsia will be seen in which veratrum is not applicable. These cases are fortunately rare; they usually occur post-partum; and are distinguished by a slow, soft pulse, prolonged coma, and great prostration.

A point of prime importance in the use of veratrum viride is the dose and the manner in which the drug should be given to obtain the best results. In the experience of the physicians with whom I have conferred, Norwood's tincture has been given the preference, and it is the only preparation I have used. Two of my correspondents have preferred veratrine. Either preparation must be used hyperdermically. The dose should be determined by the rapidity of the heart's action. Usually, the initial dose should be twenty drops. The full effect of this dose requires about thirty minutes; this is manifested by the slowing of the pulse. If at the expiration of thirty minutes, the slowing of the pulse has not been produced, the dose of twenty drops must be repeated one or more times, until the pulse falls below sixty, and thereafter, the drug must be administered in gradually smaller and less frequent doses according to the results observed. Upon this point the result of the treatment depends. With a pulse below sixty there need be no fear of further convulsions. Doubtless, the treatment sometimes fails because of the too early cessation of the injections. For at least twenty-four hours they should be continued in ten or fifteen drop doses as often as the pulse rises above sixty.

This paper is not an argument. It is my purpose to give you these facts from my own experience, and from the experience of my fellow practitioners. Yet, I may venture the opinion that the treatment is rational, since the two leading and essential indications, viz., the control of the convulsions, and the promotion of elimination by the skin and kidneys, are effectually met by it.

I consider the drug, even in large doses, absolutely safe. Emesis may be induced, but by the same sign the os becomes relaxed and delivery facilitated; and the emesis is easily controlled.

My confidence in veratrum viride is puerperal ecampsia is equal to my faith in quinine as a remedy for malaria.

Eclampsia is almost invariably encountered at a time when all concerned are poorly prepared to meet it. The patient is worn with hours of suffering; the husband and friends have had their endurance tried to the limit; and the physician is drawing heavily upon his reserve nerve force. Upon this scene of weariness and anxiety comes unannounced this new enemy and the over-taxed physician is face to face with an appalling responsibility. Surely, in such an emergency he needs to be armed with a reliable weapon,

of feeble-minded children by sterilizing these persons who would become the parents of feeble-minded children.

In closing I want to say that the material, the ideas, and in perhaps too many instances the language of this paper has been gathered from my reading; but I wish to acknowledge particular indebtedness to the article of Mr. Brewster and to the various writings of Dr. Goddard, of the Vineland Training School.

—o—

VERATRUM VIRIDE IN PUERPERAL ECLAMPSIA.

DR. F. M. WILEY, Fredonia, Kansas.

Read before the Kansas Medical Society May 7, 1913.

The use of veratrum viride in the treatment of puerperal eclampsia, is not new. Lusk, in his 1892 edition accredits Dr. Fearn of Brooklyn with first calling the attention of the profession to the use of the drug. In the American Journal of Obstetrics, for May, 1871, Dr. Fearn contributed an article on veratrum viride in large doses, as a substitute for blood-letting in puerperal convulsions.

In this article he recommends the tincture of veratrum in doses varying from 15 minims to a teaspoonful, repeated every five or ten minutes, until the pulse becomes soft, or vomiting sets in. He advises the veratrum to be administered in smaller doses for several hours after the convulsions are arrested, in order to keep the pulse below fifty to the minute. He states that the large doses are devoid of danger so long as the convulsions continue.

At the period when this article appeared, the practice of blood-letting for eclampsia was in favor, and in fact, was almost universally resorted to, and the profession seems to have been deaf to Dr. Fearn's plea for the substitution of veratrum for the sanguinary procedure.

Lusk, after referring to Dr. Fearn's article, states that after carefully watching the cases to the end he was led to conclude that the claims of bleeding in eclampsia rested upon a substantial foundation, and that it formed the first step in the treatment. As late as 1909, in the April meeting of the Mississippi State Medical Society, several prominent physicians advocated bleeding, and the author of a paper on eclampsia condemned veratrum, claiming that it weakens the heart's action, and does not favor elimination.

DeLee, in his monumental work, issued March, 1913, consigns veratrum to oblivion with the statement that, "large experience does not sustain it. In the author's experience the drug has not

altered the result either way, and he seldom uses it, and then only in the puerperium."

On the other hand, during the past twenty five years the Journals have published scores of articles advocating its use and relating the personal experience of the authors in support of it. In the main, these articles have come from physicians practicing in the rural districts, who modestly report from one to a dozen cases treated mainly or wholly with veratrum, with a very low rate of mortality, or none at all.

Edgar gives it a place secondary to chloroform, yet, in his description of the use of veratrum, he ascribes to it virtues and effects far superior to those of chloroform. He states that with the pulse strong as well as rapid, it offers the most certain means at our command for temporarily, and even permanently controlling the spasms.

To Dr. J. R. Willets of Wilson County, Kansas, belongs the honor of discovering the marvelous effects of veratrum in the control of eclampsia. This was in 1874, and Dr. Willets had not seen or heard of Dr. Fearn's paper on the subject, published three years previously. Dr. Willets was a close student of the effects of medicines. The case in which he first used the drug was one in which thirty convulsions had occurred in about twenty-four hours, persistently resisting treatment by bleeding, chloroform, chloral, bromides and morphia. Reasoning from the effects of veratrum in pneumonia and other diseases accompanied by a high blood pressure, Dr. Willets used twenty drops of Norwood's tincture of veratrum viride hyperdermically, and followed it with an equal dose in an hour. The result was a prompt cessation of the convulsions and a gradual recovery from the coma, which had been profound throughout the attack. He afterward used the drug in six additional cases with success. His experience was related in a paper read before the Wilson County Medical Society, and published in the Kansas Medical Journal. The result was a prompt adoption of the treatment by the physicians of Wilson County, with whom it has continued in constant favor until the present time.

Recently, I addressed a circular letter to the members of the Wilson County Medical Society asking for their experience in the use of veratrum in eclampsia; in answers to the following questions:

1. Have you used veratrum in these cases?
2. In how many cases have you used it?
3. Have you depended upon veratrum exclusively, or have you used it with other remedies?
4. What number of cases have proved fatal to the mother?

5. Do you think, from your own experience, that any other single remedy is superior to veratrum?

6. Have you a theory as to the favorable effects of veratrum in eclampsia?

7. What preparation do you use?

Fifteen gentlemen favored me with replies. All had used the remedy in a total of eighty-six cases, not all, however, occurring in Wilson County. Eight physicians report that they have depended upon veratrum exclusively; six have used it with other remedies, mentioning bromide per rectum, chloroform, elaterium, calomel, salines, morphine and tropine, Abbott's H. M. C. Compound, amyl nitrite and immediate delivery; but have placed their main reliance upon veratrum, and ascribe to it the favorable results obtained. One physician reports three cases treated with veratrum in conjunction with other remedies, all of which recovered, though he failed to get the characteristic effects of veratrum. In answer to the fourth question, four deaths are reported, or a mortality rate of four and sixty-five hundredths per cent. Thirteen physicians affirm that they consider no other single remedy superior to veratrum, and six consider veratrum a specific.

The theories of these gentlemen as to the action of veratrum are as varied as the views of the etiology of eclampsia held by the profession in general. While I do not purpose to enter into a discussion of these theories, a mere enumeration of them may be of interest. They include:

1. Reduction of blood pressure—relaxation.
2. Diaphoresis and diuresis—elimination of poison.
3. It acts as a superior systemic antiseptic.
4. It acts as an antispasmodic and equalizer of the circulation.
5. It reduces temperature.
6. It simply holds the patient until proper elimination can be effected.
7. It inhibits the heart's action, thus relieving the congestion of the spinal cord.
8. It stimulates the vagus.

Personally, I have used veratrum in seven cases, all of which recovered. In each of four cases there was but a single convulsion; two patients each had a second convulsion, and one had five before they were brought under control, and a sixth fourteen hours later, after I had left the patient and was depending upon the oral administration of veratrum to control the pulse and the convulsions.

Occasionally a case of eclampsia will be seen in which veratrum is not applicable. These cases are fortunately rare; they usually occur post-partum; and are distinguished by a slow, soft pulse, prolonged coma, and great prostration.

A point of prime importance in the use of veratrum viride is the dose and the manner in which the drug should be given to obtain the best results. In the experience of the physicians with whom I have conferred, Norwood's tincture has been given the preference, and it is the only preparation I have used. Two of my correspondents have preferred veratrine. Either preparation must be used hyperdermically. The dose should be determined by the rapidity of the heart's action. Usually, the initial dose should be twenty drops. The full effect of this dose requires about thirty minutes; this is manifested by the slowing of the pulse. If at the expiration of thirty minutes, the slowing of the pulse has not been produced, the dose of twenty drops must be repeated one or more times, until the pulse falls below sixty, and thereafter, the drug must be administered in gradually smaller and less frequent doses according to the results observed. Upon this point the result of the treatment depends. With a pulse below sixty there need be no fear of further convulsions. Doubtless, the treatment sometimes fails because of the too early cessation of the injections. For at least twenty-four hours they should be continued in ten or fifteen drop doses as often as the pulse rises above sixty.

This paper is not an argument. It is my purpose to give you these facts from my own experience, and from the experience of my fellow practitioners. Yet, I may venture the opinion that the treatment is rational, since the two leading and essential indications, viz., the control of the convulsions, and the promotion of elimination by the skin and kidneys, are effectually met by it.

I consider the drug, even in large doses, absolutely safe. Emesis may be induced, but by the same sign the os becomes relaxed and delivery facilitated; and the emesis is easily controlled.

My confidence in veratrum viride in puerperal eclampsia is equal to my faith in quinine as a remedy for malaria.

Eclampsia is almost invariably encountered at a time when all concerned are poorly prepared to meet it. The patient is worn with hours of suffering; the husband and friends have had their endurance tried to the limit; and the physician is drawing heavily upon his reserve nerve force. Upon this scene of weariness and anxiety comes unannounced this new enemy and the over-taxed physician is face to face with an appalling responsibility. Surely, in such an emergency he needs to be armed with a reliable weapon,

and in my opinion the very best he can have at hand is veratrum. Especially fortunate is he, if he can run to the dressing table and find a hyperdermic already loaded with twenty drops of Norwood's tincture.

O

AUTO-INTOXICATION.

DR. M. S. THACHER, Turon, Kansas.

Read before the Kansas Medical Society May 7, 1913.

It is not the purpose of this paper to cover the field of auto-intoxication, nor to enter deeply into the scientific bacteriology and organic chemistry which a thorough discussion of the subject requires. Nor will I dwell much upon those obscure intoxications which have their origin in the perverted function of the ductless glands. But will limit its scope to a brief review of the so-called auto-intoxications which have their origin in the gastro-intestinal tract, and discuss it from the standpoint of the general practitioner.

Auto-intoxication is a term used by the profession to describe a multitude of pathological conditions, the etiology of which is more or less obscure, and on which there is a wide diversity of opinions.

Albu defines auto-intoxication as "the poisoning of an organism by the products of its own metabolism; which products may be normal in character but excessive in amount, or abnormal in character."

Bouchard says that "the human body is both a receptacle and a laboratory of poisons." The word poison fills one with dread, and the red poison label with its skull and cross bones commands the respect of the most careless. Yet the intestinal canal always contains immense amounts of poisons, with only a thin absorbent membrane between them and the general circulation. The blood itself is loaded with products which would soon prove fatal but for the organs of defense and elimination. But if the body is in a healthy condition, we ingest them with impunity, manufacture them to our benefit, and excrete them harmlessly.

It is the abnormal absorption of, or the absorption of abnormal amounts of these poisons, or their faulty elimination which we have to deal with in gastro-intestinal auto-intoxication.

Albu has given us the most satisfactory classification of auto-intoxications. He divides them into four classes as follows: First, Auto-intoxication caused by failure of function of definite organs. These are affections of the glands, usually of the simple atrophic

type, as myxedema, acute yellow atrophy of the liver, pancreatic diabetes, etc. These organs by their failure of function permit the accumulation of toxic products in the system.

Second, Auto-intoxication by general anomalies of metabolism without evident localization. These are diseases in which the intermediate products of metabolism and the products of retrograde metamorphosis reach the general circulation. To this class belong uricæmia in general oxaluria, gout, etc.

Third, Auto-intoxication through the retention of the physiological products of metabolic action in the different organs. In this group are included the severe manifestations following burns,, carbon dioxide poisoning of dyspnoea, uremia, etc.

Fourth, Auto-intoxication through excessive production of the physiological and pathological products of an organism. These are hydrothionæmia, acetonuria, diaceturia, cystinuria, diabetic coma, etc.

The auto-intoxications of gastro-intestinal origin may be classed as exogenous and endogenous. The exogenous toxins are those which develop within the tube itself. Von Norden claims these should not be classed as auto-intoxications, as they have not yet been absorbed. There are two theories as to the development of the exogenous toxins. The old theory that the products of incomplete normal digestion were absorbed as toxins seems to have few adherents now. Taylor says, "There is not a single reported experimental or clinical fact which is explained by the assumption of the resorption and non-detoxication of the digestive juices; for it has been shown that the products of normal digestion ever act as poisons."

The theory that most of these toxins are the products of bacterial fermentation and putrefaction is now pretty well established. These bacteria are always present in the intestinal canal and have a part in normal digestion. As their forms are numerous so the toxins which they develop are legion. There seems to be no question that these toxins are present in normal digestion. They are often found in abnormal amounts in healthy individuals. Yet their presence in excess in the feces, blood, or urine is often associated with conditions of auto-intoxication.

The question arises, why are these substances injurious in some cases and not in others? Why do not all people suffer from auto-intoxication?

Most investigators have worked on the theory that the system tolerates normal amounts of these toxic products. But when they are found in excess, absorption is excessive and the de-

fenses are overwhelmed. Metchnikoff, working upon this theory, has endeavored to change the intestinal flora by replacing the putrefactive bacteria, with the bacillae bulgaricus and others, whose products are non-toxic.

It seems to me that a study of the condition of the mucosa itself is one that has not received the attention it should, and that more extensive research along this line might prove fruitful. In reviewing the literature on this subject I have been impressed with its association with conditions of inflammation or irritation along some portion of the digestive tract.

Inflammation may be the etiological factor by altering or impairing the normal secretions, which having germicidal properties, inhibit the excessive development of the bacteria of putrefaction and fermentation. Strasburgh, who has made an extensive study of the bacteria of the intestinal tract, and has developed technique for the estimation of the quantitative content of the bacteria of the feces, estimates that only .07% of those excreted with the feces are livable at the time of excretion.

It is generally admitted that normal mucous membrane arrests some of the toxins and prevents their absorption, but I have been unable to find the result of any research which would reveal the difference between the absorptive properties of the healthy membrane and one which is irritated or inflamed.

A partial list of the inflammatory diseases of the gastro-intestinal tract which are associated with auto-intoxication, and which might owe their toxic symptoms to the inflamed mucosa are acute and chronic gastritis, acute and chronic enteritis, and entero-colitis, and mucous colitis and appendicitis.

Wood in a recent paper on this subject shows that it is often associated with appendicitis and entero-colitis and describes several cases that were cured of their auto-intoxication upon the removal of the appendix.

Irritation without real inflammation may be responsible for the absorption of toxins in such conditions as over loaded stomach, gastric dilation, gastroptosis, constipation, and obstipation. In these conditions, the food remaining too long in the stomach or bowels, the decomposition products irritate the mucosa, causing congestion and altered function, and thus permitting the absorption of toxic products.

Some investigators believe that auto-intoxication is usually due to altered function of the organs of defense and elimination. Mulot goes as far as to say that there is clinical and experimental

evidence that gastro-intestinal auto-intoxication is merely a symptom of liver insufficiency.

The symptoms that are due to gastro-intestinal auto-intoxication are numerous and varied, prominent among which are malaise, headache, confusion of mind, loss of memory, mental irritability, insomnia, indefinite pains, vertigo, aching limbs, neuralgias and neuritis. These are associated with bad breath, flatulence, gastro-intestinal disturbances, various skin eruptions, functional heart disturbances and asthma.

Among the chronic diseases, which may have their origin in auto-intoxication are arterio sclerosis, chronic rheumatism, arthritis deformans, nephritis, exophthalmic goitre, anæmia, acnæ, eczema, melancholia and others.

The presence of indican in the urine, indicates the absorption of putrefactive products, but its absence does not eliminate a diagnosis of auto-intoxication.

Forchemier says, "The physician should never make the diagnosis of intestinal auto-intoxication until he has made a careful differential diagnosis, eliminating everything else." This is doubtless good advice, but I believe we can conversely say, in many chronic diseases a diagnosis is incomplete until we have eliminated gastro-intestinal auto-intoxication as an etiological factor.

The cases of this trouble that I have had most experience with have been retired farmers, as every community in Kansas has its quota of retired farmers, it is with them in view that I will make a few suggestions for treatment.

These patients have spent an active out-door life. They have been used to a rich diet and plenty of it. They come to town and lead lives of inactivity. The appetite becomes variable; if waning, they try to tickle by it a greater variety of indigestible viands.

However, they more often eat too much. Their inactivity leads to constipation. They form the pill habit, which exaggerates the trouble. After a round of patent medicines, they come to the physician with deranged digestion, a weakened heart muscle, more or less sclerosed blood vessels and a goodly number of the above mentioned toxic symptoms.

Constipation, or constipation alternating with diarrhoea is one of the symptoms that is present in nearly every case. The patient will often declare that the bowels are regular. But on closer questioning will admit that he takes his favorite pill at bed-time or if he has a passage every day, examination will often reveal a fecal mass on the left side above the sigmoid.

The first, and most important indication for treatment is

dietetic, and this is usually most difficult, as you not only have to teach an old man, who has always eaten anything and everything, he wants, how to restrict his diet; but to teach an old lady, his wife, who considers herself a famous cook, how to cook and what to cook, or more particularly what not to cook.

No hard and fast rule for diet can be laid down. The time may come when we may, by chemical examination of the urine and feces, be able to tell what poison is producing the symptoms and by eliminating it's source from the diet, eliminate the toxin. But as yet we have few land marks along this line. Excess of indican in the urine, being a product of putrefaction is an indication for with drawing meats from the diet.

Usually a light vegetable diet gives the best results. In some cases a plain milk or buttermilk diet is required. Some advocate sugar solution. Unless there are complications, few medicines are required. As soon as the bowels are cleaned and the liver unloaded cathartics and salines should be abandoned. The patient should be encouraged to drink lots of water. It flushes the system, washes away some of the toxins, and helps to keep the patient from eating too much. I am a firm believer in hydrotherapy of the pure H_2O type, taken in large quantities internally.

I have found colon flushing once or twice a week efficacious, though Von Norden and others condemn it. Massage, vibration and electricity are helpful. I have some of these patients come to the office every day and give them a thorough abdominal massage.

The patient should be encouraged to take regular, light exercise. Associated inflammatory conditions should receive appropriate medical or surgical treatment.

TOAST—"THE DOCTOR."

DR. S. L. BROOKING, Osawatomie, Kansas.

Delivered before the Kansas Medical Society at a dinner May 7, 1913, at Topeka.

Mr. Toastmaster, Ladies and Gentlemen:

In responding to this toast, I will not tell you of the names of those illustrious in the history of medicine; nor will I follow the doctor along the flowery paths of literature; nor, yet, along the lines of scientific attainment, or research; nor will I be lead off by any side issues such as Christian Science, which can not boast of any christianity or science—but which is simply a disease—like the hobble, the hipless figure, politics or poker; nor will I allude

to those who keep two automobiles and have a summer address; who are always on the point of going to Europe for special study; and who, in richly furnished apartments, under the guise of specialists, pose as great doctors, who charge more for one half hours work, and get it too, than a Country doctor will get in a week. I will have something to say of that Country Doctor; not the great Country Doctor, like Ephraim McDowell of Kentucky, who was the first person in the world to perform the operation for ovariectomy; and who practiced it for a decade before the rest of the world knew that it was possible. Now, the women on whom the operation was performed—Jane Crawford—is being historically remembered, her grave becoming almost a Mecca. Nor, do I wish to speak of another type of country doctor, like one I met in consultation many, many years ago, on the banks of the Marais des Cygnes, in Miami County, Kansas.

I had a case of pneumonia, and when the young man's lungs filled up, I candidly told his folks I could do nothing further for him. His friends suggested that I hold a consultation with a certain Doctor Smith, who lived south of the Pottowatomie, about four and one-half miles south, and west, of where the State Hospital at Osawatomie is today. He was sent for; in an incredible short space of time he arrived. I had been informed that he stood high in his profession. If I had had any doubts on that subject, they vanished as he entered the door, for he was six feet, two inches and three quarters high. I noted that his left eye was missing; which one of his friends told me had been "put out" by coming in contact with the spur of a rooster in a cock-fight. I, also noted, that the upper part of the lobe of his right ear was gone; which one of his admirers told me "had been chewed off in a dog-fight."

Ladies and gentlemen—I was a young, unsophisticated youth, having just graduated from the Jefferson Medical College, Philadelphia, having barely attained my majority. It is true, one of my uncles said, I had "gone to Philadelphia a gosling and came back a goose." However that may be, I am afraid you will coincide with my uncle, when I tell you, at that time I had an implicit confidence in the efficacy of drugs. So then, even the outlandish appearance of this consulting doctor(?) did not faze me, for, I yet hoped that something could be gained from experience, that some good might come out of this Nazareth. So, I told the doctor (?) my diagnosis—which was evident—my prognosis which seemed certain, and the remedies that I had used, which I assure you were in accordance with the teachings of the Professor of

Medicine in the Jefferson College, and practiced in the Hospitals of the City of Philadelphia. Without paying the least attention to what I said, he simply looked down on me with his wall eye and said, "Doctor, did you ever try a black cat skin poultice in these cases?" In my youthful ignorance and inexperience, I confessed I never had. He then said to me, "young man, your education has been neglected, for I assure you, it is the most **sovereignest remedy** that can be used." I soon saw from the looks of those who stood around the bedside of the dying boy, that they thought I had committed an error of omission; and from the sinister glances of those nearest and dearest to him, no diagram was needed to show me that my absence was more desired than my presence. I will not dwell long on this painful part of this story, I will simply tell you, I stood not on the order of my going—but I got——— The next morning I heard that all that night the slaughter of the cats went on. Oh! if the mother cat could have known of it there would have been heard "A voice in Ramah—Rachael weeping for her children; refusing to be comforted because they were not."

I also heard, that the doctor(?) said, that "if he had seen the patient a **leetle earlier** and could have gotten a **leetle blacker cat**, that he could have saved his life in spite of the fool practice of that young Philadelpha doctor."

So, between these two extremes—the great country doctor McDowell on the one hand, and this ignorant country quack on the other, there are hundreds and hundreds of country doctors, that go to make up our county societies, which are a part and parcel of our great state society. Of that country doctor will I speak.

The young doctor just graduated from college—before the ink has had time to dry on his diploma—with his pocket case full of new, bright, unused instruments—looks out on this world as his oyster; which, with his scalpel, he will open. He has no fears—whatever, about his success, financial, social or professional. For in his imagination, he sees patients flocking to him from every quarter. They come from the hills, near the lofty mountain peaks, where the snows never melt; they come down from the deepest vales, where the roses ever bloom. He listens with credulity to the whispers of fancy—he pursues with eagerness the phantoms of hope. He thinks that age will fulfill the promises of youth, and that the deficiencies of today will be supplied by the plenty of tomorrow. To get himself squared on this proposition; to be entirely disillusioned—he will only have to pay attention to the lot of the average country doctor. For, we who have practiced medicine for years—who have borne the heat and burden of the

day; who have grown gray in its service and wear the marks of its burdens—we know there is the bitter, as well as the sweet in its ministrations.

No one who has a cold heart, that knows no sympathy should be a doctor. It requires the warm heart that throbs for 'others woes; for it is the seamy side of life we must often see, and the notes borne to our ears, whether musical or discordant, are pitched in a minor key. To this warm hearted and sympathetic doctor, no night is too dark, or too cold, no road too rough or too long, to prevent him from attempting his errand of mercy, if he thinks his effort will be appreciated.

Mark Antony said in his oration over Caesar that "ingratitude, more strong than traitors arms, quite vanished him." How often does the doctor find and feel this ingratitude sharper than a serpents tooth? How often are we approached by individuals with tears in their eyes and voices trembling with emotion, pleading with us to attend some one, near and dear to them; promising to remunerate us far beyond our expectations or our hopes? After the arduous trip has been made; after we have summoned and used our utmost skill and care, and success has crowned our efforts, and we take the lonely road home again, go to our office and in a little book, kept for that purpose, make some hieroglyphics, that represent an equivalent for this toil and care; and after waiting a reasonable length of time and then thinking we may be previous, we wait another reasonable time; and then to make assurance doubly sure and take a bond of fate, we wait still a longer time and send in a modest and a meagre bill. And if soon thereafter, we should be so fortunate, or, mayhap, so unfortunate, as to meet this individual, who pleaded with us so hard, the chances are, he will fail to recognize us, pass by on the other side, or, if he should speak, will do so in a gruff voice and say, "I intend to pay that bill when I get able; but I don't want to be hounded to death about a little thing like that." Some of these fellows seem to aim to pay their bills by pretending to get angry at the manner in which they are presented. If we should have a subsequent call from one of these gentry, as good a plan as any, is to emulate the actions of the doctor described in these lines, entitled, "After Poe—A Long Way.":

Once upon a midnight dreary,
The doctor slumbered weak and weary.
And all the town could
Hear him snore.
While he lay there sweetly napping,
Suddenly there came a tapping;

Like a ram-goat madly rapping
His hard head upon
The door.

"Get thee up!" a voice cried loudly,
"Come at once!" he shouted proudly,
Like a man who owned a million,
Or much more.

But the doctor never heeded—
Back to dreamland fast he speeded.
For such men as that he needed
In his practice
Nevermore.

For long months that man had owed him.
Not a cent he'd ever paid him.
And the doctor now will dose him
Nevermore.

But one of the hardest things we are called upon to hear; one that fills our cup to the brim with the bitterness of gall and wormwood—a cup doubtless which we each and all have drained—is, where, after we have been the family physician for years; entered into their joys; and sorrows, have been the recipient of their most private confidences—for the doctor carries keys to enough closets, containing family skeletons, to make him the most dangerous enemy to society, or its best friend—after we have seen the children grow up from little tots, and have been looked upon by them as their "guide, philosopher and friend"—after all this, to expect of us the impossible. Incurable disease comes in—a member of the family dies—when a change takes place that rivals the metamorphoses of Ovid. Our old time friends become our most bitter enemies; forgotten are all the doctors midnight vigils, his hours of toil, and care; his tramping his chamber floor at night, cudgelling his brains to devise some plan, somehow, in some manner, to avert, or mitigate, the attack of the fell destroyer—all, all are forgotten! They vanish among the mists of things that were. "A school boy's dream, the wonder of an hour."

Often, too often, this state of affairs is brought about by the **intentional**, casual, dropping words by the doctor called in consultation, to some member of the family, or friend thereof: "Too late now, if I had been called in earlier, **something** might have been done" These words have often caused incalculable harm. Is it any wonder that some doctors shy at a consultation, especial

ly with those, who would have us think they have such an enormous practice, that they are willing to travel for miles and miles, at half price; or hold a consultation for one dollar and a half! Annoyances, such as these, coupled with others, doubtless inspired these lines:

To be day and night, at the beck and call,
Of men who cheat, and women who lie;
To know how often the scoundrels live,
And see with sorrow the dear ones die;
To be laughed to scorn as a man who fails,
When nature claims her terrible debt;
To give to the mothers her first born's smile,
And leave the eyes of the husband wet;
To face, and brave, the gossip and stuff
That travels about through a country town;
To live in the dread of malpractice suits—
And fight all terrible scandals down;
To study at night, in papers hear
Of new diseases and human ills';
To work like a slave for weary years
And then be cursed when you send your bills.

But this is but one side of the picture; it has another and a brighter side. Although we doctors are so often mistreated by an ignorant, or a malicious laity; or by traitors within our own ranks; yet we are so philosophical—made more so by practice—that what would spoil the temper, and ruin the disposition of any other class of men, becomes to us, in time, the source of a pleasant reminiscence. No one is so well acquainted, or comes in such close contact with their patrons, as does the doctor; knowing their foibles and their faults; their vices and their virtues; and knowing them as we do, know that the good immeasurably predominates over the bad. For, we are not always mistreated; nay, often remembered liberally in a material way with a thankfulness that makes our heart rejoice. Besides these material remembrances, there are others, so dear to us that we would not part from them for gold, silver or diamonds. Those of us who have been in practice for only a decade or two, must remember instances that illustrate those principles of honesty, integrity and generosity—principles that soar aloft above the groveling things of earth—catching inspiration from immortal God, adorn our poor humanity, and make us think better of our species, and of ourselves.

Oftimes, while combatting disease, which has crowded us

back, inch by inch, until we can almost hear the rustle of the wings of the Angel of Death that hovers over our patient. At last we succeed and drive back the Grim Monster—who turns and flees, and leaves his victim free. Then, we are rewarded by the sincere, heartfelt thanks of some good wife, or mother, and feel the hearty handclasp of a husband, or father, and hear the words so generously spoken. At such times as these what care we for long rough roads? What care we for the dark, cold night, with its storms of rain, or hail, or sleet, or snow? What to us are such obstacles? They vanish like the mist before the rising sun—they are scattered like dew drops, shaken from the lions mane.

One of the best illustrations of the country doctor is that given us by Ian McClaren, in "The Bonnie Briar Bush" of Dr. Wm. Mc Clure. Rough, and brusque, except to women and children, who love him as if by instinct; not a church going man, and the user of language that seemed profane to the deeply religious scottish community in which he lived; he wore out his life in forty years, attending to their wants. No ford was too dangerous, no snow-drift too deep, no road too rough, or too long to deter him from attending them—riding his faithful old gray mare, Jess.

We all remember the assiduity with which he fought death, all night, at the home of the cottager Saunders; we remember the zeal with which he entered into the plan to get the great surgeon to save the life of Annie, the wife of Tammass. We see the surgeon, and the doctor, seated in the doctor's buggy, crossing the swollen ford of the Tochtly, swollen far beyond its wont; when the passage became so dangerous that the surgeon arises from his seat, and says, "Dr. McClure, you must turn around and go back, for I would be eternally condemned if I allowed myself to be drowned to save any body's life." "Sit doon!" said McClure, "condemned you may be, but you will cross the ford with me the day." The ford was crossed, the operation was successful, Annie's life was saved; and when Dreumshaugh so painfully wrote the check for one hundred guineas, and gave the doctor to give the surgeon, he said, "Dr. McClure, you had a right to think meanly of me at the ford yesterday, but not so meanly as to think I would take this check," and tore it up. And shortly thereafter, the villagers saw the great surgeon conversing with the doctor at the station; and when the train pulled in to carry him away, he shook hands with Dr. McClure and said, "Doctor, I am proud that I have met you."

But, at last the end came to him, as, Mr. Toastmaster, it must come to you and me; as it must come to us, each and all! His old

friend Dreumshaugh is with him, and the Doctor asks him to read from his mother's Bible, which naturally opens at one place, and Dreumshaugh read, "And the publican standing afar off would not lift up so much as his eyes to heaven, but smote upon his breast, saying, 'God be merciful to me, a sinner.' '" "That might hae been written for me, Paitrick," said the doctor, "It was na easy to gang to Kirk, but I could hae managed it wi a stretch; and I used langidge I sudna, and I was too rough, and short in the temper. I see it noo—it's ower late to mend, but maybe yeil just say to the fouk that I was sorry, and that I hope the Almichty will hae mercy upon me. Cud ye pit up a bit prayer for me, Paitrick?"

"I hae na the words," said Dreumshaugh in great distress. "Wud ye like tae send for the minister?"

"It is no the time for that noo," answered the doctor, "an a wud rather hae yersil—just whats in your Paitrick."

So with trembling voice and many pauses, Dreumshaugh knelt and prayed. "Almichty God—dinna he hard on Weelum McClure for he's been na hard wi onybody in Drumtochty—Be kind to him as he has been to us all for forty year—We are all sinners afore Thee—Forgive him what he's dune wrong an dinna cast it up against him—Mind the fouks he's helpit—the wimmen and the bairnies and gie him a welcome home, which he is in sair need after ah his wark. Amen."

Though never the recipient of any outward tokens of regard, or esteem from the warm-hearted, though dumb-of-speech people among whom he lived; yet when the funeral came—the worst day in years—every able-bodied man in Drumtochty, Kildrummie, Muirtown, Upper Artach, Dumleith and Glen Artach **all** forced their way through the perilous snow-drifts, and icy streams, to his humble cottage; as he had oftentimes fought his way to theirs. They came to show their respect and esteem, for the dearly beloved doctor. After listening to the service at the grave with bared heads in the chilling blast, Lord Kilspindie paid his tribute to his dead friend, and craved the privilege of erecting a monument over his grave. He asked the good minister to suggest a fitting text to inscribe on it. Without hesitation came the answer, "Greater love hath no man than this, that a man lay down his life for his friends."

Isn't it better to have earned an inscription like that, than to have piled up money for people to quarrel over after we are gone?

And Mr. Toastmaster, when we have written our **last** prescription—when we have made our **last** call, and have gone down to the tongueless silence of dreamless dust, and the final summing

up shall come; and if some cynic, or pharisee in Paola, or in your town—or yours—or yours—should say about, as did the man Milton about Mr. McClure, "Nae doot Dr. McClure had mony natural vartues, and he did his wark well, but it was a great peety he didna maik mair profession of releegion." May we not hope that some kind friend will say for us, as did Lachlin Campbell for Dr. McClure, "God's judgment of Dr. McClure is written in the gospel, but it is not Weelum McClure that will be expecting it."

"What is it, Lachlin?" said Jamie Soutar, eagerly.

The old man, now very feeble, stood in the middle of the road, and his face, once so hard, and lined, was softened in winsome tenderness, as he repeated, "Come ye blessed of My Father—I was sick, and ye visited me."

—o—

"WHAT ARE WE GOING TO DO ABOUT IT."

DR. CHAS. E. SEIVER, Holton, Kansas.

Read before the Kansas Medical Society, May 7, 1913.

Many perplexing questions are now confronting the medical profession and some important ones are about to reach the crisis. While it is not the scope of this paper to bring before you each of these questions, it is my desire to mention the most important ones and then leave it to you as, "What we are going to do about it."

Medical science, there can be little doubt, has made wonderful advances within the profession, but with the great masses of the laity there has been no such advancement; in fact, there seems to be a renewing of all the superstitious beliefs and practices along medical lines which today are all nestled sweetly together in the so-called league of medical freedom.

This has been brought about largely by our lack of development along certain lines; not only have these lines been undeveloped, but they have been left to wither by the way-side, and the sad fact in regard to this is that from this withered product the whole system of medicine had its origin. I mean to tell you that we have neglected to develop one of our most important branches, viz., therapeutics; you can't conceive of a physician of olden times without a bunch of herbs, this was their main equipment; most of these were sought and found where nature planted them and were dug and prepared into the proper form for administration by the physician himself. Many of these were good medicine for certain diseases, but the idea I want to convey is the closeness of

the physician to his medicines, and the knowledge he obtained of each drug, and after the preparation of same he watched the therapeutic action of each one at the bedside of his patient. It seems to me that we have learned enough about therapeutics to know that there is great value in some drugs in treating certain diseases. If this be true, is it not possible a thorough search and study might find many more of equal value? We know that suggestion does good. We know that in certain cases massage is beneficial and that many of the different baths and mechanical treatments are useful in the treatment of disease, then why not study and fully develop all of these; none of them are, nor can they be a system of medicine.

What we should have then is a better system of studying drugs and their actions; suggestive and mechanical therapeutics and the way to obtain the best results from same. This should be provided in our medical colleges. Our medical students come out of college almost a blank in materia medica and therapeutics and have little knowledge of the real value of suggestive and mechanical therapeutics; that is why the professional medical houses find such a friend in him; that is why 75% to 80% of young physicians prescribe almost altogether from the literature of these houses. Each medical college should have at least two good men devoting all their time to experimental therapeutics. Pharmaceutical houses are a good thing in their place; but they have no right to dictate to the doctor what he should use, but on the contrary the doctors' formulæ should go to them for preparation, if it is more desirable to have it done there than at the local drug store. Most of our leading pharmaceutical houses compound some simple remedy, giving it a pleasant taste and a big, uncommon name, and the doctors have been doing the rest and the patient has been paying about ten prices for an ordinary drug. We need to get back to first principles, to know more about crude drugs, to know what they look like, what they taste like and then we cannot be lead to believe we are giving some wonderful medicine, instead of an ordinary one dressed with a little different flavor. These crude drugs could be studied and the different processes of making medicines from them could be taught in detail along with the study of materia medica, and therapeutics. Were this done the end of the ordinary pharmaceutical house would be in sight; physicians would compound their own medicines, or would have them compounded by a local drug store. Then instead of sending the patient away with a few ready made pills we would have a new compound of whatever form we desired to make for his case; he would feel that

he had gotten more for his money, and all would be better off, as self-drugging would be brought almost to a minimum, for the people would not know what to call for; the druggist would not be so free to suggest because he would not have the literature of the pharmaceutical house as his guide. If it is more convenient for the physician to send his R to a druggist, I believe there should be a new law covering ownership of the R , the R is only an order on a druggist to prepare certain medicine for a certain person and that it is always the property of the physician; a law could be enacted about as follows: When a doctor gives a patient a R , the patient takes it to a druggist who prepares the medicine and stamps across the face of it with a special stamp that this R has been filled and is hereby cancelled; the druggist then files it away for a limited time, say thirty days for his own protection, during which time it is not to be refilled and at the end of which time it is again returned to the doctor who wrote it, just as checks are returned to the party who wrote them after they have fulfilled their mission at the bank. Such a law would be a good thing, not only for the physician, but also for the druggist, and the people at large, as it is an undisputed fact that the indiscriminate refilling of the doctors prescription, is the source of a great deal of harm, in fact, it becomes no more than ordinary patent medicine.

Another very important question is that of laws governing the public health and sanitary questions. We need more uniformity of board of health laws, and more uniformity of the laws covering the right to practice medicine. We now have many good laws covering nearly every phase of public health but they differ somewhat in many of the states and should be gone over by the authorities of the different states and by cutting out here and putting in there form a general law covering the fundamental principles of public health and sanitation, and urge its adoption by every state in the Union. Then a campaign of education should be started to teach each citizen of the U. S. that respect for these laws will mean longer life and less suffering for all of us. The medical registration or practice laws are closely linked with the public health laws, or at least with the proper enforcement of same. There is perhaps only two or three states that have an ideal practice law. I mean by ideal one which requires every applicant who desires to practice medicine to take the same examination and to have the same preliminary and college education. Why should we pass and try to enforce laws covering the spread of contagious diseases and then license men and women to go out over the state to practice who do not know one of these diseases from another, and worse

than that, we have a so-called Christian Science Sect, which I think are as devoid of science as they are of christianity who take the stand that there are no germs and consequently no diseases, and yet this same class are practicing in Kansas today and while they do not recognize the existence of germs or disease, they are all quite sure that the $\$$ does exist and without it they can not afford to fool with any of the mortal illusions which have no real existance.

The masses of the people need to be taught the silliness of such doctrines. All so-called pathies, or side lines of medicine are along a similar line. If all had to take the same examination governing the whole field of medicine, there would only be one kind of a physician, and he would be a physician indeed. All these side branches are just a short step, an easy way to get out before the people as a doctor. Who ever sends for such as these when they are really in distress or pain? Can best illustrate this by telling of a little boy who got a fall while playing and severely injured one of his limbs. His mother at once called an osteopath doctor; he came and fumbled and fussed around with the boys limb, worked at his spine, etc., after he had gone the mother asked the boy if it hurt his sore limb while the doctor was treating it. The boy quickly replied, say "ma do you think I was fool enough to let that fellow fool with my sore leg?" "I gave him the well one to rub." Who ever sends for them when great calamities happen, such as wrecks, floods or storms? I even doubt whether our honorable governor whom you supported so loyally should he be so unfortunate as to have a bone broken or a joint misplaced, would send for one of his late creation and have his spine rubbed until the offending member flew back into place.

The only solution then is for the medical profession to start a campaign of practical every day education along the line of medicine and keep at it until we accomplish in the U. S. what has been done in the Panama Zone. As my closing words let me ask you again, "What are we going to do about it?"

.....—O—.....

The Inaugural Symptoms of Gall-Stones—The error that has found a place in the minds of all medical men, and has been faithfully carried down from one generation of textbooks to another—that in the majority of cases gall-stones cause no symptoms—has been forever dispelled by the work of the surgeon. In operating in cases of advanced cholelithiasis a history of inveterate, though perhaps trivial dyspepsia over a long period can almost always be obtained.—Sir Berkeley Moynihan, Address in Surgery, Brit. Med. Assn., 1913.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdell, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

Beginning this fall Harvard University and the Massachusetts Institute of Technology are to maintain in co-operation a School for Public Health officers. The facilities of both institutions are to be available to students in the School and the Certificate of Public Health (C. P. H.) is to be signed by both President Lowell and President MacLaurin.

The object of this school is to prepare young men for public health work, especially to fit them to occupy administrative and executive positions, such as health officers or members of boards of health, as well as secretaries, agents and inspectors of health organizations.

Thus again, Kansas has shown the way in the field of progress, the idea being originated and fathered by Dr. S. J. Crumbine and carried out under his supervision in the University of Kansas.

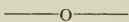
—O—

An altruism of Dr. Wm. Osler's quoted by Dr. Hiram Woods (Jour. A. M. A. September, 1913), is as follows:

"The doctor who lives to himself is a most dogmatic and dangerous animal. The patient watches his every expression; the nurse takes what he says as law and gospel; the family waits at the foot of the steps to get the latest news, and rejoices or trem-

bles at the great man's verdict. After a while he gets to believe it all himself. Only when he touches elbows with his fellow doctors does he reach his true level, and because of this he owes it to himself and his patients not to forsake the 'assembling of yourselves together.' "

No truer words have ever been spoken. Certainly association keeps the doctor from becoming self-centered, self-conscious, lordly and egotistical.



An amusing decision was recently handed down by the Court of Appeals of Georgia, and noted in the Journal of the A. M. A., September 20th. It is as follows:

Right of Recovery for Services Though Not Beneficial—(Hall vs. Mooring (Ga.), 76 S. E. R. 759)—The Court of Appeals of Georgia says that this was a contest between two members of the gentler sex. The plaintiff was a practitioner of the art or science of osteopathy, and the defendant either needed, or thought she did (which was the same thing) the services of the plaintiff. Several visits were made at \$3.10 per visit, the ten cents being added for streetcar fare, and the whole bill amounted to \$27.90. The defendant said that she paid all she really owed and that the plaintiff charged her for a number of social calls, during the course of which the defendant was importuned to continue the treatment. The defendant said that she declined to do so and that the services rendered by the plaintiff gave her no relief and were so unsatisfactory that she was forced to resort to a physician of the allopathic school, who administered pills and mixtures in the good old-fashioned way. On the issues of the fact the plaintiff outswore the defendant, or at least the jury in the justice's court thought she did, and the judge of the superior court refused to interfere. This was the end of the law so far as this branch of the case was concerned. It would never do to hold that a doctor is entitled to recover only where he cures the patient. If the court did, the members of this learned profession might hesitate to respond in extreme cases where the chances were against them. So far as this court is concerned, the doctors may continue to bury their mistakes and recover for their services as they have always done. If the court were dealing with lawyers, the rule might be different. The defendant said that she ought not to pay the extra ten cents per visit because the plaintiff usually walked. The plaintiff testified, however, that the charge was usual and reasonable. If so, she had a right to walk and save the ten cents.

The last session of the state legislature which sought to legalize Chiropractics, inserted a clause in the law, which seems to nullify its workings. It provides for a separate Board of Examination and Registration composed of three chiropractors who have practiced within the state for two years previous to the enactment of the law. One school teacher and one preacher. Now the Governor has rightly refused to appoint a board which obviously would have to be violators of the medical practice act of 1901, to qualify. So the chiropractors have brought mandamus proceedings in the supreme court or will do so at an early date, to compel the governor to appoint said board. It is hard to see how the supreme court can uphold a law of this character and they probably will not do so. Now there are chiropractors springing up all over the state and apparently practicing, at least to the extent of having offices putting up signs and advertising to cure all kinds of diseases in their particular way (manipulation of the spine.) They are violating the law and it is our duty as law abiding citizens to see that the law is enforced. We should get busy, obtain the evidence and present it to the public prosecutor.

—o—

EDITORIAL CLIPPINGS.

Successful prosecution of illegal practitioners of medicine depends first of all on the disposition of the authorities to prosecute. There are exceptions, but as a rule our courts are ready and willing to get in behind genuine fakers who are violating the medical practice act, if anything like proper evidence is forthcoming. Officers have long since learned that it does not pay to arrest alleged violators of any law merely on suspicion, unless a real crime has been committed. It is not sufficient to believe or even to know, that a law has been violated; there must be positive proof before the courts can afford to convict. The thing for us to do then, if we desire to enforce the medical practice act, is to assist in securing the evidence. Whenever we undertake prosecutions in earnest and go about it in a intelligent manner, success usually follows our efforts.—Texas State Journal of Medicine.

—o—

No More Typhoid in the Army—Typhoid fever has been banished from the United States Army. When our soldiers are needed, hereafter the American people can feel sure that, as far as this disease is concerned, the full strength of each company and regiment will be on the firing line. In previous wars, from 10 to 40 per cent of the opposing forces have been in the hospitals, incapaci-

tated through various diseases. During the Spanish-American War, out of 10,759 soldiers in camp at Jacksonville, Fla., there were 2,693 cases of typhoid. If this division had been in the midst of an active campaign, its fighting strength would have been weakened about one-third, not only by the loss of these patients, but also by the loss of the men necessary to care for and transport them. Any means which will reduce or eliminate any of the diseases from which soldiers have suffered in the past, will actually increase both the strength and the efficiency of the army. It will also greatly increase the chances of our volunteer soldiers returning safe from war, as disease has, in every war in history so far, killed more soldiers than bullets. An official announcement of the elimination of typhoid from our army is an event in which every citizen should feel a keen interest. In a recent issue of *The Journal of the American Medical Association*, Major Frederick F. Mussel of the Medical corps summarizes the results secured through vaccination. In 1902, with an enlisted strength of 80,778 men and officers, there were in our regular army 565 cases of typhoid. In 1909, out of 84,077 men there were 282 cases. In March, 1909, vaccination was begun, but the number vaccinated that year, 830, was too small to affect the ratio. In 1910 over sixteen thousand were vaccinated, and at once the number of typhoid cases began to diminish. In 1911 there were only 70 cases. In the same year vaccination for typhoid was made compulsory on all persons in the military service and on all recruits. In 1912, the first year in which the entire army was immunized, there were only 27 cases, the last one occurring Dec. 19, 1912. Since that date, now nine months ago, there has not been a single case of typhoid in the army.

Major Russell also reports that during the past four years over 200,000 persons have been vaccinated without a single death or injurious result. Such an experience on so large a scale certainly justifies his conclusion that by the general use of vaccination typhoid fever will soon become a negligible factor in our public health problems.

—o—

SOCIETY NOTES.

Program of the Harvey County Medical Society for September:
"TUBERCULOSIS".

"Tubercular Adenitis," Dr. A. E. Hertzler.

"Tubercular Pneumonia," Dr. A. E. Smolt.

"Tuberculin Treatment," Dr. Max Miller.

THE JOURNAL OF THE Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus.

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

Beginning this fall Harvard University and the Massachusetts Institute of Technology are to maintain in co-operation a School for Public Health officers. The facilities of both institutions are to be available to students in the School and the Certificate of Public Health (C. P. H.) is to be signed by both President Lowell and President Maclaurin.

The object of this school is to prepare young men for public health work, especially to fit them to occupy administrative and executive positions, such as health officers or members of boards of health, as well as secretaries, agents and inspectors of health organizations.

Thus again, Kansas has shown the way in the field of progress, the idea being originated and fathered by Dr. S. J. Crumbine and carried out under his supervision in the University of Kansas.

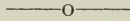
—o—

An altruism of Dr. Wm. Osler's quoted by Dr. Hiram Woods (Jour. A. M. A. September, 1913), is as follows:

"The doctor who lives to himself is a most dogmatic and dangerous animal. The patient watches his every expression; the nurse takes what he says as law and gospel; the family waits at the foot of the steps to get the latest news, and rejoices or trem-

bles at the great man's verdict. After a while he gets to believe it all himself. Only when he touches elbows with his fellow doctors does he reach his true level, and because of this he owes it to himself and his patients not to forsake the 'assembling of yourselves together.' "

No truer words have ever been spoken. Certainly association keeps the doctor from becoming self-centered, self-conscious, lordly and egotistical.



An amusing decision was recently handed down by the Court of Appeals of Georgia, and noted in the Journal of the A. M. A., September 20th. It is as follows:

Right of Recovery for Services Though Not Beneficial—(Hall vs. Mooring (Ga.), 76 S. E. R. 759)—The Court of Appeals of Georgia says that this was a contest between two members of the gentler sex. The plaintiff was a practitioner of the art or science of osteopathy, and the defendant either needed, or thought she did (which was the same thing) the services of the plaintiff. Several visits were made at \$3.10 per visit, the ten cents being added for streetcar fare, and the whole bill amounted to \$27.90. The defendant said that she paid all she really owed and that the plaintiff charged her for a number of social calls, during the course of which the defendant was importuned to continue the treatment. The defendant said that she declined to do so and that the services rendered by the plaintiff gave her no relief and were so unsatisfactory that she was forced to resort to a physician of the allopathic school, who administered pills and mixtures in the good old-fashioned way. On the issues of the fact the plaintiff outswore the defendant, or at least the jury in the justice's court thought she did, and the judge of the superior court refused to interfere. This was the end of the law so far as this branch of the case was concerned. It would never do to hold that a doctor is entitled to recover only where he cures the patient. If the court did, the members of this learned profession might hesitate to respond in extreme cases where the chances were against them. So far as this court is concerned, the doctors may continue to bury their mistakes and recover for their services as they have always done. If the court were dealing with lawyers, the rule might be different. The defendant said that she ought not to pay the extra ten cents per visit because the plaintiff usually walked. The plaintiff testified, however, that the charge was usual and reasonable. If so, she had a right to walk and save the ten cents.

The last session of the state legislature which sought to legalize Chiropractics, inserted a clause in the law, which seems to nullify its workings. It provides for a separate Board of Examination and Registration composed of three chiropractors who have practiced within the state for two years previous to the enactment of the law. One school teacher and one preacher. Now the Governor has rightly refused to appoint a board which obviously would have to be violators of the medical practice act of 1901, to qualify. So the chiropractors have brought mandamus proceedings in the supreme court or will do so at an early date, to compel the governor to appoint said board. It is hard to see how the supreme court can uphold a law of this character and they probably will not do so. Now there are chiropractors springing up all over the state and apparently practicing, at least to the extent of having offices putting up signs and advertising to cure all kinds of diseases in their particular way (manipulation of the spine.) They are violating the law and it is our duty as law abiding citizens to see that the law is enforced. We should get busy, obtain the evidence and present it to the public prosecutor.

—o—

EDITORIAL CLIPPINGS.

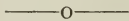
Successful prosecution of illegal practitioners of medicine depends first of all on the disposition of the authorities to prosecute. There are exceptions, but as a rule our courts are ready and willing to get in behind genuine fakers who are violating the medical practice act, if anything like proper evidence is forthcoming. Officers have long since learned that it does not pay to arrest alleged violators of any law merely on suspicion, unless a real crime has been committed. It is not sufficient to believe or even to know, that a law has been violated; there must be positive proof before the courts can afford to convict. The thing for us to do then, if we desire to enforce the medical practice act, is to assist in securing the evidence. Whenever we undertake prosecutions in earnest and go about it in a intelligent manner, success usually follows our efforts.—Texas State Journal of Medicine.

—o—

No More Typhoid in the Army—Typhoid fever has been banished from the United States Army. When our soldiers are needed, hereafter the American people can feel sure that, as far as this disease is concerned, the full strength of each company and regiment will be on the firing line. In previous wars, from 10 to 40 per cent of the opposing forces have been in the hospitals, incapaci-

tated through various diseases. During the Spanish-American War, out of 10,759 soldiers in camp at Jacksonville, Fla., there were 2,693 cases of typhoid. If this division had been in the midst of an active campaign, its fighting strength would have been weakened about one-third, not only by the loss of these patients, but also by the loss of the men necessary to care for and transport them. Any means which will reduce or eliminate any of the diseases from which soldiers have suffered in the past, will actually increase both the strength and the efficiency of the army. It will also greatly increase the chances of our volunteer soldiers returning safe from war, as disease has, in every war in history so far, killed more soldiers than bullets. An official announcement of the elimination of typhoid from our army is an event in which every citizen should feel a keen interest. In a recent issue of *The Journal of the American Medical Association*, Major Frederick F. Mussel of the Medical corps summarizes the results secured through vaccination. In 1902, with an enlisted strength of 80,778 men and officers, there were in our regular army 565 cases of typhoid. In 1909, out of 84,077 men there were 282 cases. In March, 1909, vaccination was begun, but the number vaccinated that year, 830, was too small to affect the ratio. In 1910 over sixteen thousand were vaccinated, and at once the number of typhoid cases began to diminish. In 1911 there were only 70 cases. In the same year vaccination for typhoid was made compulsory on all persons in the military service and on all recruits. In 1912, the first year in which the entire army was immunized, there were only 27 cases, the last one occurring Dec. 19, 1912. Since that date, now nine months ago, there has not been a single case of typhoid in the army.

Major Russell also reports that during the past four years over 200,000 persons have been vaccinated without a single death or injurious result. Such an experience on so large a scale certainly justifies his conclusion that by the general use of vaccination typhoid fever will soon become a negligible factor in our public health problems.



SOCIETY NOTES.

Program of the Harvey County Medical Society for September:
"TUBERCULOSIS".

"Tubercular Adenitis," Dr. A. E. Hertzler.

"Tubercular Pneumonia," Dr. A. E. Smolt.

"Tuberculin Treatment," Dr. Max Miller.

Review of Recent Literature or Report of Case, Dr. J. L. Grove.

—o—

The Northeast Kansas Medical Society will meet at Leavenworth, October 30th. There will be an afternoon and evening session commencing at 1:30 p. m. and 7:30 p. m. From 4 to 6:30 an automobile ride will be given the visitors by the Leavenworth doctors, and a dinner at 6:30. A most excellent program has been arranged, consisting of the following:

"Carcinoma of the Female Breast," Dr. J. C. Shaw, Holton.

Gall-Stones, C. J. McGee, Leavenworth.

Arterio-Sclerosis, L. F. Barney, Kansas City.

Eclampsia, E. Smith, Lawrence.

Trachoma, C. L. Zugg, Kansas City.

Paper—P. B. Matz, Leavenworth.

Some Remote Effects of Local Infection, W. T. McDougall, Kansas City.

Role of the Connective Tissue, A. J. Sundwall, Kansas University.

Differential Diagnosis of Upper Abdominal Diseases, R. C. Lowman, Kansas City.

Talk—P. T. Bohan, Kansas City, Mo.

Concussion of the Tympanum, R. S. McGee, Topeka.

L. V. SAMS, President. C. C. GODDARD, Secretary.

—o—

The Southeast Kansas Medical Society held its semi-annual meeting at Chanute, September 30th, under the presidency of Dr. O. S. Hubbard. The following program was given:

The Conjunctival Flap and its Use, Dr. W. H. Graves, Pittsburg.

Ulcer of the Stomach—Its frequency, its relationship to carcinoma, operative treatment, results; Dr. Robert B. Gibb, Pittsburg.

Paper—Dr. N. C. Morrow, Altamont.

Trachoma, Dr. C. A. Landes, Parsons.

The Fact vs. the Mental Impression; the senses do not present Nature as it is but make a world of their own. Dr. W. R. Heylman, Iola.

The So-Called Social Evil. Its fundamental cause, the vital principle involved, society's effort for correction, the doctor's position, no cure, an improvement. Dr. P. S. Mitchell, Iola.

Physicians and Druggists, Co-Workers, Not Competitors, Mr. I. G. Fowler, Druggist, Independence.

The Sanatorium Treatment of Tuberculosis, Dr. J. A. Milligan, Garnett.

What is Wrong With The Medical Profession of Kansas? Medical Legislation, Feeling of the Legislature toward the medical profession, results obtained, where the fault lies is in not getting better recognition, Dr. Chas. S. Huffman, Columbus.

Rheumatoid Arthritis. A lecture illustrated with lantern slides, Dr. Lindsay S. Milne, Kansas City.

—o—

The Mississippi Valley Medical Association will hold its 39th annual session at New Orleans, October 23-25. A trip to Panama has been arranged following the meeting, for the benefit of the members and their friends. Particulars may be had from the secretary, Dr. Henry E. Tuley, Louisville, Ky.

—o—

Butler County Medical Society met at Eldorado, August 21st. Papers were all good, well prepared and fully and ably discussed. Thirteen physicians were present and all participated in the work of the session. One new member was admitted. Following is the program:

Paper—Malformations in the Newborn, with Report of Cases, Dr. N. E. Wilson, Douglass. Discussion led by Dr. H. A. Hill, Augusta.

Paper—Herpes Zoster, Dr. C. A. Spray, Towanda. Discussion led by Dr. J. B. Carlile, El Dorado.

Paper—Para-Typhoid Fever, Its Prevalence and Diagnosis, Dr. Wm. McKinney, Latham. Discussion led by Dr. R. J. Ca-been, Leon.

J. R. McCLUGGAGE, Secretary.

—o—

NEWS NOTES

Dr. Charles A. Boyd of Belpre, was married September 10th to Miss Cora Belle Klein of Iola.

—o—

The date for the semi-annual meeting of the Northeast Kansas Medical Society has been changed to October 30th. A program of unusual merit has been obtained. REMEMBER THE DATE.

—o—

Millions for Research Bureau—Mrs. George William Hooper, San Francisco, is said to have transferred to the University of California, \$1,000,000 for the establishment of an institute of medical research. The foundation is to be controlled by an ad

visory board of seven members, consisting of the president of the Carnegie Institute, the professor of pathology at Johns Hopkins University, the director of the Rockefeller Institute for Medical Research, the president and dean of the medical school of the University of California, a representative of the donor and a member to be chosen by the western members of the advisory board.—*Ohio State Medical Journal*.

—o—

Dr. I. H. Munn spent two months touring the east in an auto. He traveled two thousand miles with no mishaps. His greatest sight on the trip (the doctor's own statement) was a ball game between Boston and Philadelphia, which went twelve innings and was won by Boston, 1 to 0. Dr. Munn is to be congratulated upon seeing a real ball game. We who live in Topeka and Kansas City, usually witness exhibitions by "Cellar Champions."

—o—

Dr. and Mrs. E. N. Robertson, Concordia, spent three weeks during the month of August, in Colorado. They made the trip in their touring car and visited all points of interest around Denver, Colorado Springs, and Manitou, traveling about 1400 miles.

—o—

Dr. R. C. Lowman of Kansas City, Kansas, recently returned from a three weeks attendance at the Mayo Clinics.

—o—

Dr. H. R. St. John, formerly of Alton, has opened an office in the Rialto Bldg., Kansas City, Mo.

—o—

The State Board of Medical Examination and Registration held its last session at the National Hotel, Topeka, October 14th. Dr. H. A. Dykes of Lebanon is the secretary.

—o—

OBITUARY.

Mott J. Gillam, M. D., Bennett Medical College, Chicago, 1886; died at his home in Florence, Kan., July 2, from cerebral hemorrhage, aged 48.

—o—

Bernard W. Slagle, M. M., University of Pennsylvania, Philadelphia, 1877; of Smith Center, Kan., while waiting at a station to take a train for Colorado, about August 24, died suddenly from cerebral hemorrhage.

—o—

Charles W. Maddox, M. D., Louisville (Ky.) Medical College, 1894; a fellow of the American Medical Association; local surgeon in Longton, Kan., for the Santa Fe System; a member of the

Atchison, Topeka & Santa Fe Railway Association of Physicians and Surgeons; died at his home in Longton, August 20, aged 41.

James Beggs Carter, M. D., Rush Medical College, 1882; a member of the Kansas Medical Society; for eighteen years a member of the Kansas State Board of Health and once chairman of the board; for several years physician of Fort Scott and Bourbon County, and local surgeon for the Frisco and Missouri Pacific Systems; died at his home in Fort Scott, September 2, from nephritis, aged 54.

REVIEWS.

Poliomyelitis—W. A. Sawyer and W. B. Herms, Berkeley, Cal. (*Journal A. M. A.*, Aug. 16), report an investigation made under the auspices of the California State Board of Health to determine the part played by the stable fly in the spread of the epidemic poliomyelitis. They give some interesting facts in regard to the life history of the stable fly. In a series of seven experiments under varied conditions they were unable to transmit poliomyelitis from monkey to monkey through the agency of the stable fly. While further studies may show this possibility, they conclude that these negative results and those of the second set of experiments of Anderson and Frost throw doubt on the stable fly as the natural transmitter of poliomyelitis. With present evidence, the policy of isolation should be still followed, and we should attempt to limit the production of human carriers and to detect and control them. Screening against the stable fly and other flying insects in a precaution that should be used. but not as a substitute for those against contact infection. Measures should be devised for the control of the stable fly and diminishing their numbers. Those against the house are not sufficient on account of its different habits. They are a great annoyance to animals, probably capable of transmitting a number of animal diseases.

Conduct of Labor Without Vaginal Examinations—Green (*Boston Med. and Surg.*, April 10, 1913), "concludes that the common custom of making frequent vaginal examinations during labor is a bad one and deserves to be classed as 'meddlesome.' These examinations disturb and often hurt the patient, they add to the risks of infection, they give no information that cannot generally be obtained by external examination, except as to the condition of the cervix, and the possibility of prolapse of the cord or a fetal

extremity. Except in hospitals, to which naturally many abnormal cases are sent, the greater majority of cases are normal as far as the fetal passenger and the maternal passage are concerned, and when delay occurs it is much more generally due to defective pains. Frequent vaginal examinations do not remedy this difficulty, and the obstetrician's efforts can be more profitably employed than in making them. The author considers the conditions which would warrant or necessitate vaginal examinations during labor. Pathological conditions usually call for operative procedure, from low forceps to abdominal section. Most of these procedures necessitate vaginal invasion; but every vaginal examination shadows the prognosis, if Caesarean section is finally decided on. Antepartum hemorrhage, pregnancy toxemias with convulsions, abnormal presentations, minor relative disproportion between pelvis and fetal head, complicating neoplasms, prolapse of the funis, and evidence of impending fetal asphyxia, surely necessitate treatment involving invasion of the vagina. But in the absence of these more or less grave complications, the only indications for vaginal examination in cases which at the beginning of parturition bid fair to be normal seem to the author to be only the prolongation of labor beyond reasonably normal limits of time, that is, ineffectiveness of the maternal powers, and suspected prolapse of the cord or a fetal extremity."—Medical Record.

—o—

MISCELLANEOUS.

A Litany for Doctors—From too few patients and from too many patients; from hypodermic syringes that won't work; from book agents; from consultants who steal our cases; from rheumatism; from collecting agencies; from stupid nurses; from people who are going to pay for visit next Saturday night; from Anti-kamia calendars; from tire troubles and Christian Scientists—good Lord deliver us.

From the people who begin their letters to us, "Dear Sir"; from static machines in damp weather; from boils on the back of the neck; from debts and detail men; from Pa-pa-yans Bell blot-ters; from anti-vivisectionists; from nurses who know more than we do; from "cures" for tuberculosis; from "textbook" papers, from incurable cases of imaginary disease; from Bernard Mc-Faddists; from tag days; from new methods for administering salvarsan; from "automobile "fractures; from infant foods; from anti-vaccinationists; from nature curers; from Immanuel Movers and the treponema pallida—good Lord deliver us.

From the people who call us "Doc,"; from malpractice suits and dead beats; from gossips; from overly-grateful female patients; from pretty nurses and jealous wives; from the doctor who succeeds us in a case; from the "wrong number" mistake; from consultations by telephone; from the counter-prescribing drug-gist; from lawyers and dentists; from samples of Sal Hepatica; from the man who wants us to help his lady friend out of trouble; from calls at two a. m; from shoulder presentations; from optometrists and engine trouble; from the man who "can not add anything to the paper, but merely wants to compliment the essay-ist;" from meta-amidopenylparamethoxychinolin; from New Thoughters and mining stocks; from breaking catgut; from neurasthenics; from "the sponge we left behind us;" and from the dangers of tricresol 0.4 per cent.—good Lord deliver us. Amem. R. R. —Lancet Clinic.

—o—

For Sale or Trade—Fine, modern, 10-room home for sale or trade for land; can be used as office and home. Good location for business. No competition near. Address L. C. R. % Journal.

—o—

Here is what happens to the Chiropractors in Missouri:

FINE FOR A CHIROPRACTIC.

Practicing Medicine Without a License the Charge Against Springfield Man.

Springfield, Mo., August 20—Dr. J. W. Fenter, chiropractic physician of this city, was found guilty on trial in the criminal court today of practicing medicine without a license and fined \$30 and costs. At a trial last July the presiding judge ordered the jury to bring in a verdict of not guilty.—Kansas City Star.

—o—

What Do They Really Tell The Reporter?—"A new use of ether as an anesthetic was introduced for the first time in this city yesterday, when physicians at the Hahnemann hospital operated on a patient after they had infused the drug into the blood. . . . The infusion is called 'hydrocele' . . . Dr. Hessler superintended the 'hydrocele'. The operation was successful."—Philadelphia Ledger.

—o—

CLINICAL NOTES

Suprapubic Prostatectomy—By the perineal method of attack

certain more or less objectionable sequelæ not infrequently occur. The approach is such that the muscular control is jeopardized, particularly in the case of large masses; and a certain number of cases of incontinence, more or less partial, is almost certain to result. Fistulæ of various kinds always have, and I believe always will, occasionally result, those communicating with the bowel being the least common but most serious.

For these reasons it seems to me that in dealing with the type of prostate in which the obstruction results from the formation of adenomatous masses, the suprapubic route has a clear advantage over the other methods of attack.—Hugh Cabot, in *Surgery, Gynecology and Obstetrics*, August, 1913.

—o—

The surgeon's scalpel should find no place in the treatment of the injuries of the hand. The advocated practice of going above the injured tissue and securing sound flap for the closure is vicious in the extreme, and has sacrificed hundreds of thousands of fingers, and hands that could have been saved for useful work, and whose commercial loss to the world cannot be expressed in figures. No one can with any accuracy foretell in an injured hand which part will recover and which will die, because no one can measure the reparative force in any given case, and hence it is but fair to the sufferer to give the benefit of the doubt to a conservative course. It is not infrequent to save useful limbs where in cases of severe injury the patient has refused amputation, and has compelled a conservative course, that resulted in restoration of usefulness and the maintenance of earning capacity.—Dr. W. P. Nicolson (*Old Domin. Jour. Med. and Surg.*, April, 1913).

—o—

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL SURGERY.

In performing brisement force of a knee stiffened by prolonged immobilization in a splint or cast, the utmost caution should be observed. Under these conditions the bones are very brittle and a fracture is easily produced.

—

Too often the fact is overlooked that, even in the absence of a visible scalp lesion, pediculosis capitis may cause painful swelling of the posterior glands of the neck, with or without cellulitis (resembling the swelling over an inflamed mastoid) and fever.

—

In the treatment of peritonitis merely raising the head of the bed is not as satisfactory as propping the patient up in bed.

In peritonitis the employment of Fowler's position should not be reserved for post-operative treatment. Use it as soon as the diagnosis is made.

Small epigastric herniæ are usually of fat and contain no sac.

Too thorough purging in preparation for a laparotomy contributes to post-operative distress. A simple laxative or an enema is sufficient for most cases, and even these can often be dispensed with. Urgent cases operated upon without any preparation usually do as well, as far as the bowels are concerned, as those previously purged.

In simple gas distention, with discomfort or actual pain, within the first thirty-six hours after laparotomy very often the most satisfactory treatment is a hypodermatic injection of morphine. A rectal injection of peppermint water may also be needed. Purges should be avoided. Eserine may help to get rid of the gas, but it adds to the pain.

The best routine management of the bowels after operation is to let them alone. An enema on the third or fourth day is usually all that is needed.

Marked post-operative abdominal distention, with nausea, belching and increasing prostration are strongly suggestive of acute dilatation of the stomach. The stomach tube and lavage are indicated as they are also in repeated post-operative vomiting.

In determining between malaria and pyogenic infection as the cause of a chill and pyrexia a leucocytosis of 20,000 or less does not necessarily exclude paludism; it is sometimes found at the outset of a malarial attack.

Now that we are able to definitely establish a diagnosis of chancre by smear and by blood test, there is no longer any reason why a genital "primary sore" should not be excised. On the contrary, the prompt removal, by this means, of its many contained spirochete is highly desirable.

THE JOURNAL OF THE Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, NOV. 1913.

No. 11

ACUTE INFECTIONS OF THE PERITONEUM.

DR. N. C. MORROW, Altamont, Kansas.

Read Before the Southeast Kansas Medical Society Sept. 30, 1913.

There is perhaps no acute condition which occurs frequently in general as well as in surgical practice, more serious than acute infections of the peritoneum; no condition in which more depends on prompt recognition and appropriate treatment; no condition in which more disastrous results follow injudicious treatment. Following a great variety of intra-abdominal pathological conditions, acute peritonitis should be recognized early by the careful physician; and if this is done and proper treatment begun early, even though in relatively unskillful hands, the results will be better than treatment at the hands of the most skillful surgeon if begun late.

Etiology—Acute infections of the peritoneum are practically always secondary. The common causes of such infections are: appendicitis; infections of the female reproductive organs, especially pus tubes; perforating ulcers of the stomach, duodenum, or of the ileum in typhoid; rupture of the gall bladder; and perforating injuries of the alimentary tract, usually gun-shot or stab wounds. Less frequent causes are: mechanical obstruction of the intestines due to twists, bands of adhesions, or internal hernia; thrombosis of any part of the intestinal tract secondary to mechanical disturbance; any hepatic or peri-renal abscess. One other cause which is more common than it should be is operative manipulation. This, I believe, is most often due not to dirty hands of the assistant, infected catgut or sponges; but to an attempt to do too much surgery in the presence of a known or suspected infectious focus. These infections commonly follow direct soiling of the peritoneal surface with infectious material, occasionally from extension through tissues, rarely by metastasis. The usual invad-

ing organisms are the colon bacillus, the ordinary pus producers, the gonococcus, and the pneumococcus. Four factors determine the severity of an acute peritonitis: the virulence of the invading organism; the patient's resistance, the amount of infectious material invading the peritoneum, and the site of the infection. The first two require no discussion. The third factor, amount of infectious material is of considerable importance in perforating ulcers or wounds of the gastrointestinal tract, and of course depends largely on the amount of distention at the time the perforation occurs. The site of infection is important for two reasons. The peritoneum in the upper part of the abdomen, especially that of the diaphragm and omentum has great absorptive powers; and the evidence of shock and sepsis is greater from lesions in this region than from those occurring lower down, where the peritoneum has less absorptive power as well as relatively greater power of resistance to infection. Then too, the contents of the stomach and upper part of the intestine produce a distinct chemical injury to the peritoneum. Although there are but few bacteria in the stomach contents, this chemical injury makes the peritoneum all the more susceptible to infection when it does occur.

Pathology—In cases with comparatively slow extension of infection through the walls of some abdominal viscus a perforative peritonitis occurs. Fibrinous adhesions form between adjacent coils of intestine and omentum; a local thickening of the peritoneum takes place, and when perforation does occur the infection is limited to a very small area. Such cases tend to spontaneous recovery or, at the most, the formation of a small localized abscess. The typical changes following an infection of the peritoneum are: congestion of the small blood vessels, exudation and inhibition of motion in the intestines and abdominal muscles adjacent to the point of infection. Congestion begins and is most marked at the site of infection; it is more marked on the visceral than on the parietal peritoneum; it also involves the omentum in the affected region. This hyperæmia is an important factor in the resistance to infection in the early stages, and may be compared to Bier's hyperæmia. As soon as it interferes with normal functions, however, it becomes an added danger. Exudation is first evidenced by slight dulling of peritoneal surface, which assumes a finely granular appearance, due to the deposition of fibrin. This fibrin rapidly increases and serves a useful purpose in glueing the coils of intestine together and limiting the field of infection. It also protects the peritoneal surface and prevents to a certain extent the absorption of bacteria and toxins into the general circu-

lation. The fluid part of the exudate may be fibrinous, serous, purulent, hæmorrhagic or it may show various combinations of these characteristics. The colon bacillus produces a thick, creamy pus, pneumococcus exudate similar to that in pneumococcic empyæmia, gonococcus, a dry fibrinous exudate, with little serum or pus; and streptococcus a thin odorless serum. The inhibition of motion in the intestine and abdominal muscles represents an attempt on the part of nature to limit the spread of infection and assist in the formation of a localized abscess. Later on, there may be a true paralysis of the intestine, due to the effects of bacterial toxins on the intestinal wall, and also to changes in the abdominal sympathetic produced by absorbed toxins. Microscopically the endothelium of the peritoneum shows early proliferative changes; the cells enlarge, their nuclei become swollen, and they divide first by direct then by indirect division. The cells thus produced, known as macrophages, have very active phagocytic powers. The surface of the endothelium is covered with fibrin, macrophages, and leucocytes, derived from the blood; there is marked small round celled infiltration of the subendothelial tissues. In cases of moderate severity and short duration the endothelial cells are not destroyed, the adhesions formed are purely fibrinous, and are quickly absorbed when the infection subsides. In more severe cases there is destruction of the endothelium with the formation of fibrous or connective tissue adhesions which are permanent. The lymphatics become filled with exudation and cells and infection is carried to the anterior mediastinal glands. Absorption of toxins produces cloudy swelling of the solid viscera, and in severe cases areas of focal necrosis may develop.

Symptoms—The cardinal symptoms of acute infection of the peritoneum are pain, tenderness, muscular spasm, nausea or vomiting, and changes in the pulse and temperature. Though varying greatly, they are practically always present at some time during the course of the disease. Pain may be of any character, and of any degree of severity. Often diffuse in the early stages, it becomes localized over the site of infection within a few hours. Tenderness is usually marked over the site of the initial lesion, though it may be so diffuse as to give little aid in localizing the point from which infection occurs. Muscular spasm is a constant and most valuable symptom in localizing the site of infection. Although, in many cases, the whole abdomen presents a board-like rigidity; one may, by reassuring his patient and by avoiding rough manipulations, secure a certain amount of relaxation. Then by the gentlest manipulations it is almost always possible

to make out an area in which the involuntary spasm is greater than elsewhere. Of course, this does not hold good in late cases of diffuse peritonitis, but in practically all cases if seen early, it is a very valuable sign. Nausea and vomiting, though nearly always present, are extremely variable; depending on the amount of stomach and intestinal contents at the onset of the trouble. Elevation of temperature is the rule, though the amount of elevation offers but little indication as to the severity of the infection. High temperature usually indicates lymphatic infection and absorption of toxins in addition to the local lesion. Subnormal temperature is commonly seen in the early stages of the most severe types, and is a grave sign. The pulse is one of our most valuable signs in determining the course of an acute peritonitis. It is almost invariably increased. As the infection progresses the pulse rate increases and its volume diminishes. The rapid, thready pulse so often described as characteristic of peritonitis, however, does not appear, till the disease has made considerable progress and the patient is in a serious condition. In addition to these cardinal symptoms we find the respiration shallow and increased in rate, due to the effort on the part of the patient to restrict the movements of the abdominal muscles as much as possible. The urine quickly becomes scanty, highly colored, and contains albumen and casts, as the result of a toxic nephritis. Leucocytosis is generally present, but the amount of leucocytosis is not a reliable indication of the severity of the infection. Distention of the abdomen is present to a greater or less degree in most cases. The patient assumes the dorsal position with knees flexed to relieve, as much as possible, the tension on the abdominal muscles. The face becomes pinched and drawn, the lips thin and blue; showing the dry, coated teeth. The tongue becomes dry and coated, the eyes sunken and anxious in expression. The mind remains clear till the very latest stage of the disease. Such a train of symptoms makes a picture which is characteristic.

Diagnosis—Occurring in the course of an appendicitis, gastric or duodenal ulcer, empyæma of the gall bladder, or pyosalpinx, the onset of an acute infection of the peritoneum should be easily recognized. Several other pathological conditions, however, closely simulate peritonitis. Among these may be mentioned acute nephritis, lead, gallstones, renal, or intestinal colic, acute infection of the abdominal wall following laparotomy, and acute intestinal obstruction. Examination of the urine, the presence of oedema, and the history should enable us to make a diagnosis in acute nephritis. The various forms of colic do not show the eleva-

tion of temperature and leucocytosis of peritonitis; abdominal distention is slight or absent; and there is no real tenderness; in fact, the pain of colic is often relieved by deep pressure. Infection of the abdominal wall produces general symptoms much less severe. The absence of distention and intestinal stasis are important points in differentiation. In acute intestinal obstruction we have the pain distention and vomiting of peritonitis; but the symptoms dependent on infection do not appear till the intestinal wall has been injured sufficiently to permit the passage of infectious material, usually three or four days. Perhaps the most important condition simulating acute peritonitis is pneumonia in children. In the early stages of this disease, physical signs may be delayed, and the pain referred to the region of the appendix. In pneumonia, however, the respiration rate and temperature are higher and more persistent, the breathing is apt to be jerky, and grunting, the abdominal rigidity will be found to relax between respirations, and may even disappear on prolonged deep pressure. The referred pain of pneumonia is superficial and is not increased on deep pressure as it is in peritonitis. These points in addition to a careful examination of the chest should enable us to make a differentiation.

Treatment—In treating acute infections of the peritoneum we should aim at four things, removal of the source of infection; provision of a means of escape for the products of infection, prevention of the spread of infection, and assisting the patient to resist and excrete the absorbed toxins. The first point, removal of the source of infection, is strictly surgical, and I shall not discuss it further than to say that all operative work should be done as early as possible, as quickly as is consistent with good work, and with the least possible manipulation of the peritoneal surface. Thus, we reduce to a minimum the toxic effects of the anæsthetic, and the shock incident to handling of the peritoneum, which at this time is most intolerant of manipulation. The second point, provision of a means of escape for the products of infection, consists solely of the establishment of drainage after operation. Extensive sponging of the peritoneal surface in an attempt to remove the accumulated secretions, does no good, for they will reform in a short time; but it does injure the inflamed peritoneum; and may spread infection to areas not previously involved. The same may be said of flushing out the abdominal cavity. Irrigation is the best known method of spreading infection. Its use is permissible only in cases of wounds of the intestine in which large amounts of feces have been spilled in the peritoneal cavity. Even

here it is of doubtful value, and may do more harm than good. The use of the Fowler position has proved to be an important aid in drainage, and in avoiding infection of the upper part of the peritoneum. The third point, assisting in limiting the spread of infection, is to be accomplished by putting the intestines at absolute rest. Active peristalsis is a most potent factor in spreading infection, and should be inhibited by every possible means. Hot dressings to the abdomen and opium to control pain, gastric lavage till nausea and vomiting stop and repeated as often as necessary, the use of enemata to empty the lower bowel, and the absolute prohibition of all food and cathartics by mouth are the means to be employed. In this connection, we may again emphasize the importance of avoiding too much surgery in the presence of an inflamed peritoneum. The last point, assisting in elimination of and resistance to the absorbed toxins is best accomplished by the use of Murphy's continuous proctolysis. By this means an adult will absorb as much as a pint of normal salt solution in an hour. The toxins in the circulation are diluted, the activities of the skin and kidneys stimulated, and the circulation improved. Stimulants are seldom needed. They are apt to act as an added burden to the already overloaded heart, and their use should be reserved for emergencies.

Finally, I realize that I have by no means covered this subject. Many points I have not even mentioned. But I have tried to bring out the most important features of a common and very serious pathological condition.

ULCER OF THE STOMACH.

DR. ROBERT B. GIBB, Pittsburg, Kansas.

Read before the Southeast Kansas Medical Society Sept. 30, 1913.

One of the most frequent and no doubt, one of the most often overlooked conditions for which we are called upon to treat is ulcer of the stomach, and duodenum. There are just as many lives sacrificed from cases of unrecognized ulcer of the stomach and duodenum at this time, as there were formerly lost many years ago through the non-recognition of the many phenomena brought about through diseases of the appendix.

When a patient presents himself to the usual practitioner presenting symptoms in the way of distress in the epigastrium belching with more or less distress after eating, chronicity and possibly some emaciation, especially after having examined the appendix,

found it free from symptoms, having learned that the patient has never had an attack of the jaundice, nor the lacerating pain of gall-stone colic, the diagnosis of dyspepsia, indigestion or catarrh of the stomach is usually made; the patient advised regarding diet, placed upon one of the many much claimed for digestives, and eventually turns up at the office of another practitioner to go through the same routine. After a couple of years of wandering, the patient growing from bad to worse all of the symptoms being greatly intensified, the diagnosis of cancer of the stomach is then made, and the patient given a few months to live. I do not mean to suggest that the general practitioner, or those who see these cases first are not careful diagnosticians, but I am of the opinion that the ulcer and carcinoma condition has never been called to their attention in the proper and emphatic manner that it should have been. Until my attention was specifically called to the great frequency of ulcer and to the extreme rarity with which a simple idiopathic deranged stomach exists I made my rulings in the same manner as above cited. Statistics prove beyond all question of doubt and conclusively that from 70 to 80 per cent of all cases of malignancy of the stomach and duodenum, have their beginning in ulcer, and it is very likely that a very large percentage of all cases of chronic stomach disturbance is brought about by one of three conditions, namely: appendicitis, gall-stones or gastric or duodenal ulcer.

The symptoms of ulcer of the stomach vary somewhat according to their location, and this fact is largely responsible for the confusion that arises in making a correct diagnosis. It matters but little whether the ulcer is duodenal or gastric. Pain in the region of the epigastrium, burning, boring and lacerating in character, sour eructations, belching, considerable formation of gas, pains usually relieved upon the taking of food and coming on from two to three hours afterward, at times hematemesis; pain relieved by the administration of alkalies; all these symptoms indicating ulcer or carcinoma of the stomach or duodenum.

Duodenal ulcer is most often confused with gall-stones. Gall-stone symptoms being very closely simulated when the ulcer is near enough to encroach upon the common duct opening, this often giving rise to jaundice.

Twenty per cent of digestive disturbances arise from the digestive tract outside of the stomach. Usually manifesting symptoms through pyloric spasm, possibly from a diseased appendix, gall-stones, etc.

Pain in the pit of the stomach or to the right of the median

line with belching, pain relieved upon taking food and especially pain accompanied with hematemesis is corroborating evidence of ulcer.

Gastric and duodenal ulcer is more often found in man than in women. About 75 per cent are found in man. Chronic duodenal ulcer is more common than gastric ulcer. The white race being more prone to the same than the negro. Thirty-two per cent of ulcers in males are gastric; $64\frac{1}{2}$ per cent are duodenal; 3 per cent being both. Ninety per cent are along the lesser curvature of the stomach, and most usually found on the posterior wall; this being fortunate on account of rupture.

Pain in ulcer situated in the body of the stomach comes on early following meals; while duodenal and pyloric, the pain comes on much later, and is relieved by the taking of food.

The great majority of ulcers in this region that do not bring about death through obstruction, perforation or in some other manner terminate in malignancy. It was only a few years ago that it was believed that a simple gastro-je-junostomy would cure pyloric ulcer, but subsequent events prove clearly that while the symptoms were greatly ameliorated, and the patient much relieved that many ulcers continued in their course and terminated in cancer, just the same. For that reason it is advisable to not only carry out your original plan that of doing a gastro-enterostomy, but to excise the ulcer as well.

There are many cases that are so obscure that a stomach analysis is necessary in order to arrive at an exact diagnosis, while I am not familiar with this class of work, I will touch upon it lightly. The presence of free hydro-chloric acid, especially if in excess in the vomitus or lavage, after the test meal, is confirmatory evidence of ulcer.

The absence of HCl. and the presence of lactic acids are presumptive evidence of malignant disease; the actual malignancy not bringing about the change, but the stasis induced by the progressive changes is the direct cause of the formation of the lactic acid.

Free nuclei of epithelium cells and of leucocytes mean presence of HCl. acid.

Epithelial cells and entire leucocytes mean absence of HCl. Large clumps of leucocytes and blood cells point to an ulcerating surface.

Sarcinae go hand in hand with the presence of HCl and stagnation of stomach contents.

Oppler-Boas bacteria in large numbers go with the presence of lactic acid and stagnation of stomach contents.

Thus stagnating contents with presence of HCl, sarcinae, yeast and free nuclei point to pyloric stenosis of non-malignant character.

As a result stagnating contents with absence of HCl and presence of lactic acid with Oppler-Boas bacteria point to malignant pyloric stenosis.

Surgical intervention for ulcer of the stomach and the duodenum in the hands of one who is reasonably skillful is clothed with no more danger than the usual appendectomy or cholecystotomy. One of the most satisfactory conditions and one of the easiest to combat today is gastric or duodenal ulcer. I do not wish to give the impression that I believe that all ulcers are surgical but I do contend that all of those cases which do not respond to treatment with any reasonable time should be considered surgical. The one great difficulty with which surgeons have to contend is the utter impossibility of getting control of these patients until they have advanced well along a malignant course. Either the diagnosis is not made or for some reason the patient will not submit. We have no difficulty in inducing gall-stone cases or appendiceal cases or many others to submit themselves to operation; but for some reason when it comes to carrying out some procedure on the stomach they refuse until they are compelled to adopt it as a last resort. In the great majority of cases if the diagnosis could be made sufficiently early and the patient would undergo surgical intervention, a simple gastro-jejunostomy or duodenostomy or a pyloroplasty would bring about ideal results with a mortality as low as two per cent. In our work at the Mt. Carmel Hospital in Pittsburg, Kansas, our most satisfactory results are ulcer cases.

In closing I would like to emphasize a few points and if they could be carried out there would be thousands of unfortunates saved who are dying a miserable death through cancer of the stomach. They are as follows: First, one of the most important causes of chronic disorders is gastric and duodenal ulcers, more especially after the age of 30. That practically all cases of cancer of the stomach have their origin in ulcer. That all ulcer cases that do not respond to medical treatment early should be surgical. That the great majority of ulcers develop and bring about death through malignancy. That dyspepsia means simply difficult digestion. That operative procedures in nearly all cases bring

splendid results with practically no mortality. That in order to secure these results the diagnosis must be made early and that many cases of carcinoma of the stomach can be cured through a surgical procedure.

—o—

THE SO-CALLED SOCIAL EVIL.

DR. P. S. MITCHELL, Iola, Kansas.

Read before the Southeast Kansas Medical Society, September 30, 1913.

Almost without exception, each edition of the daily press, has for a head-liner, the narration of an unfortunate and unhappy story of social relationship. It may be a simple escapade, a desertion of wife or husband, in which one of the opposite sex plays a role; or the sudden termination of a young and beautiful life in an attempt to hide the shame, placed upon her by her friends, many of whom are congratulating themselves on escaping detection from a similar act.

The desire for the exciting places the demand upon the newspapers; and it, spurred to action, through strong rivalry, heralds the story in the glaring lime-light, thus becoming the brunt of of jest, song and burlesque.

The bold reflection of the above has caused the writer to search for an underlying, vital or physical principle involved, if such there be, and see if we, as physicians could not aid society in her heretofore vain efforts.

Realizing full well that I am entering upon ground where angels fear to tread, I feel all the more conscious of its burdens resting upon our shoulders. None like the physician are escorted into the secret precincts of individual's troubles and errors. I need not remind you how often you have buried away, never to be resurrected, the secrets of a wife, husband, daughter or son from their nearest family ties, I need not call to memory how often in all true and simple confidence, a wife has innocently called upon you for advice, about which she dare not interrogate her husband. You see the first approach of the wrinkled caput as it comes into being, watch it grow and develop, and the last to hold the hand with the flitting pulse at the brink of eternity.

Every phase of human life is observed and studied, not from the view-point of the novelist, idealist or sordid orthodox; but from life as it is. Therefore, the physician is the best fitted to work out these problems and lead the way.

We need but read history, to be informed that the experiences

of the past are merely repeating themselves in this great social reform movement, now sweeping the world over. Each succeeding generation sees it cloaked, only in a little different color. An excellent history of these movements may be read in the new Encyclopedia Britannica, and a boiled down original article by J. E. Mears of Philadelphia, in the edition of August ninth, this year's Medical Record.

So we come to the cause of this maelstrom of trouble. As new and changed methods of living are evolved to make life happier and more efficient, coordinately problems of pain and evil arise to be solved. The telegraph, telephone, pullman coach and automobile, all have added their part to our comfort and at the same time have contributed no little role in this great drama, that is being cried down, even by its many actors. Intraspection is seldom practiced. Everyone is crying reform; but reform as now used is a term that means to change the other fellow's ways and never applies to one's self. Charity, on which the Nazarene lays so much stress, is almost unknown. Acts, when performed by self, are always justified by the doer, but when seen in others, are considered criminal. The predominant problem seems to be the avoidance of detection and when one is caught then all cry thief.

This is a false premise on which to live and must ever entail its troubles. We are reared upon ideals, given novels of sentimental character to read, that ever convey the idea, that one woman is born in the whole wide world for one man; and through mountain and sea, they are attracted by unseen heavenly power. They are married and after the honeymoon is over, they find merely the commonplace things in life in each other, then commence to wonder if heaven did not give them a "bum steer." The ever constant association of the sexes gives the opportunity for other familiarity with those of the opposite sex and another heavenly attraction or in common press parlance an affinity, is found. Although I have decided views on the marriage question, I must leave it here for the question, more nearly within our province of giving advice, viz., the rearing of the next generation.

For many years women have demanded a larger freedom, the emancipation of her sex and equal rights with men. Slowly but surely, the evolution is being attained and whether right or wrong, it will be hers, all before we're aware. The new freedom is here. We would not turn it back if we could, and it is a self-evident fact we cannot.

Incidentally as the new woman emerges from the cloister of

the home, the redlight closes. A larger freedom is spreading promiscuousness in the home districts. Those who assume that the redlight is being closed by the reformer's strict vigilance are blinded by the dazzle of their own reflectors. It is the freedom of the new woman and the demand thereby placed upon her by the patronage of those places. It is the inevitable evolution of life. The redlight closes and the question of home immorals cloaked in in a different garb confronts us.

Reputable women, in their newer freedom, become more closely associated with men, thereby furnishing greater opportunities for violation of the moral code. Men are discarding the redlights and wine for the more exclusive opportunities furnished in the home. The new woman is giving her daughter a greater freedom, who quite easily adjusts herself to the paths of least resistance. For some years women have crowded out the male from the school-room, as clerks in our stores and now in most cases they are chosen as the intimate and private secretaries of our men of business affairs.

With her more familiar knowledge of business and greater economical independence, her desire for excitement grows and her taste for pleasure is less easily satiated. The increased knowledge of affairs broadens her field of vision. She has her own money, sees more of the world by association, travelling, moving pictures and the like. Her demands are ever met by the avaricious desire for money on the part of the professional entertainer. She gets what she desires.

If married, she still desires the pleasures furnished by the world and the first thing learned is how to have the sexual pleasures without conception; a form of prostitution found as frequently in the long-faced reformer as the girl of the red paint.

If a child is born, the lure of pleasure still attracts and it is allowed to drift in the stream of its own inclination with little or no restraint that the parent may maintain her own pleasures. Now to the point most strikingly noticeable to the physician. We enter the post-partum room and observe a grandmother or aunt carrying and coddling the new born babe to hush its cries. In forty eight hours the babe by instinct knows that crying brings carrying, and it is disciplining the household instead of the mother putting it under discipline. Months later, incidentally, we are in the home again and find the mother answering every whimper of the child with a run to its bed, if it even gets out of her arms. When the child is a few years of age the physician may be called again in case of illness and find a stubborn pouty individual who

positively refuses to allow any examination whatsoever and when held by the doting mother kicks and maltreats her. In other words, the child has the mother under discipline. At the age of twelve, the child no longer being under control and observation seeks its own company. The parents spend their time in their own amusement or business, justifying their procedure by saying, they cannot control the child. When at sixteen they are still choosing their own companions and time for their entertainment. No companionship or anything in common exists between parent and child; they know nothing of their own physical nature and go wildly ahead, pleasure being their only goal. If a boy, his mind is unemployed and asks nothing of his parents with the exception of money to spend. His time is spent in pool halls and loitering places. The parent now scolds and chastises, wondering why he has such a wandering boy.

If the child is a girl, she spends late hours at night, in dance halls, joy-riding or entertaining her male friend on a secluded porch or dark parlor. The parents may acquiesce in this, not notice it or object to it; but matters little now what their attitude may be, for the seed has already been sown and now deeply rooted. I need not tell you what follows the late hours alone. This is where the newspapers and average reformer takes up the story, grinds vice into mincemeat and serves it at every meal. The vile young man is butchered in every mouth and the young lady is ostracised. Each critic forgets, that perhaps their boy or girl are associating in a similar manner and it is this close association of the sexes, alone and unrestrained that brings about only what nature demands. The holding of a hand, promiscuous kissing or caressing is a certain path to the brink. Nature is no dictator of morals or censor of society's choice of good; but largely a creature of habits. Good and evil are but relative terms and they answer to our definition, only at the will of society and early training.

Reasoning from the above I am going to make a statement, which, no doubt will be sharply disputed, viz., the sex virtue of our country is largely up to the female. In making this statement I do not give the male lief or license, far from it. Let us analyze the two sexes, assuming both are normal, and uninfluenced by early self-polution. In extreme early childhood the male is conscious of his sexual being, at puberty it is practically an open book to a vast majority; he is aggressive and fearless, talking about his desires and informing himself with but little modesty, which the

male possesses to a relatively small degree. His general aggressiveness is cultivated to meet the larger problems of the business world.

The normal female is positively asexual before puberty and at puberty becomes a twittering, giggling being, conscious of her new life, but the sex uninterpreted to her. If she holds herself aloof from the kisses and caresses of the opposite sex, she remains oblivious of real sex feelings. If she entertains the caresses of the male, her sex bursts forth as a fire in tinder.

Masturbation in early life, if not carried to the extreme, probably has but little if any influence on the boy for the future man, but it probably plays a great part in preparing the young girl as a victim to young men's advances. It has even been known to develop natures that cause the girl to make advances to men. These cases I must treat as abnormal, and are not within the province of my paper; however, many could be avoided by vigilant watchfulness on the part of the parent and constant employment of the child's mind.

The male, by nature, in all things is aggressive. He is the fighter and protector. He prides himself in the same, and the purest, noblest womanly woman loves and admires those qualities. We note every day, the women passing by those of the so-called finer mental qualities for the aggressive physical type. This may not be according to society's ideals, but is a fact nevertheless.

The female is the shy, retreating, negative element. By trend on the defensive. By instinct says no when she means yes. Till her sex is awakened to her, her defense and objections are of power and value. It is a reality. Afterward it is one of her most vulnerable points. The male enjoys his first and every intercourse, the female often requires repetitions of the act through periods of months before the pleasure is hers, while frequently there are cases who go through life suffering the tortures of child-birth and never experience pleasures incident to the sexual climax. Thus not from the sentimental, but physiological viewpoint, the problem of sex virtue falls more largely upon the females' shoulders.

Can we bring to an end these errors of social environment? No. It is by instinct the only incentive to the preservation and propagation of the race. These conditions and errors are properly construed as abnormal and intemperate by society's method of living and not by nature. Society's attempt to modify nature to a better way of living is perfectly right; but she should not endeavor to modify nature with one hand and flaunt the opportunities for natural desires in the face with the other. Is it possible to im-

prove conditions? Yes. Present conditions may be improved to our better liking; but each year will bring about its new problems to be solved. The pleasure and pain in life will ever be proportionate to its population. Therefore it is essential to keep up the effort to make a better social life to even maintain that equilibrium and cope with the new problems arising. As small-pox, yellow fever, black and white plague disappear before the magic hand of science; cancer, insanity, neurasthenia, diabetes and the Bright's diseases increased to employ our efforts.

What is the physicians' part to play? With his storehouse of knowledge of the physical being and human nature, he may be a leader of thought in a community and not usurp any field from the spiritual leaders. Where he can be of greatest service is in the post-partum room, which I desire to make the basis of my remedy.

When the new mother and recently born babe are tucked away snugly in their clean bed, the physician owes it to the world to tarry a few minutes with a few pertinent words of advice along the lines of developing the future man or woman just born. The usual instructions of feeding and hygiene should be properly given. They should be told that hunger and gas on the bowels are the source of a vast majority of infant's crying, and how to properly remedy the same. Teach them not to carry the child from the first. If it frets (be assured it is not ill) turn it over and let it cry to sleep. Here the battle is half won. On the other hand a few days of carrying requires months to correct. As it passes through babyhood, keep it ever under kindly discipline and avoid answering its whim of crying with coddling. When it emerges from babyhood into childhood, maintain discipline and employment of the mind. Never allow it to obtain its wishes by crying or other means when once refused. Keep its mental and physical being employed by healthy entertainment without its knowledge of your intent. Remember idleness is the devil's workshop. Be a companion of its own age with it, and you will maintain its respect and desire to be with you. Books will interest some, the workshop or garden entertain others, while music and art have their charms for many.

When fourteen to sixteen, continue the companionship, and the discipline now is a natural consequence. Caution and guide the boys; guide their relationship with girls in a channel of open out-door sports; at all times discourage late hours and secluded meetings. Furnish them entertainment in the open without their knowledge in your effort.

Tell the girls the larger problems by nature, falls upon them. Tell them of the dormant fire smouldering within, ready to be fanned into a terrific blaze; if she but furnish the opportunity. Warn them of questionable language, whether private or public. Impress upon her, that the main secret lies in avoiding familiarity. Repeat to her never to allow boy or man to lay a hand upon her, kiss or caress her, till she is certain their future ties are sealed. This, to the writer's mind, is the open sesame to the secret precincts of woman's virtue.

This, I believe, to be the prevailing factor in all errors of the young. No one but woman herself holds the key to the situation. When her sex is unawakened and she has had the proper advice, it comes perfectly natural to her to modestly and easily maintain her self-respect and honor. A word or look has saved many a girl at this point from future remorse. However, it occurs frequently, that the young lady spends many hours late at night, kissing and carressing one who has no more intent of matrimony than she, with no remonstrating word from a parent.

Society should frown upon the intimate and loose association of the sexes and thereby inculcate the idea into the individual that the child might get the proper advice. When this intimate association cannot be prevented, no one is made better by the punishment heaped upon him by recently enacted laws. Legislators should learn that there is a vast and wide difference between the villanous crimes of murder and theft where the incentive can only be felonious and a digression from the moral code, where the incentive is the strongest of natural desires. They should know that the enticing of a young girl from her home, placing her in a house of debauchery for remuneration is not a moral physical desire like two young lovers feel in their caresses when left alone.

There is too much veneer in the reform of today. The mask should be torn off our ideals, expose and treat the underlying principle, not from a criminal but physiological standpoint.

Sane legislative restriction most certainly is necessary and works for the greater good; but like all laws that govern the least, govern the best. No county or municipallity ever legislated good into her people.

This a home problem and must be worked out as such with the careful advice from those who know well the physical body. Taking the work up in the school is yet a debatable question; but in the writer's judgment, should be carefully experimented with.

Segregation of vice is inexcusable and unattainable. Torture in prison will do little or no good. We will always have it with us

in some form. We will not be able to radically improve it. The incentive is there and as long as the sexes are loosely associated, regardless of resolutions and ideals it will be in our midst. The frequency with which our brethren among the spiritual leaders are enmeshed in the social net does not signify viciousness on their part, but demonstrates the error of the intimate association of the sexes.

To obtain results we must prevent those opportunities. Men and women are not bad at heart. The home must be the foundation stone of it all. The very objectionable phases may be corrected, probably will correct themselves. However, ideals are never attained, and nothing is absolute in nature. With every condition improved to enhance our happiness, coordinate problems of evil and pain spring up to be solved.

I offer no cure, only a remedy to help. I am aware if every physician offered the above advice to every parent at their children's birth, many would fail to be impressed, many would lack the mental qualities to grasp the situation, many children would fail to grasp the idea, many children will steal away and practice self-pollution, and many are left parentless, thereby leaving them a pitiless environment at a sensitive age.

So, after all, we may only expect to smooth out the larger waves in this troubled sea of life and the smaller ripples with now and then a crest, will ever be there until the end of time.

—O—
TRACHOMA.

DR. C. A. LANDES, Parsons, Kansas.

Read before the Southeast Kansas Medical Society, Sept. 30, 1913.

It is indeed strange that so little attention is paid to a disease which is filling our institutions for the blind and causes years of untold suffering and agony.

While dealing with the more salient points of trachoma, my principal endeavor in this paper will be to bring forcibly to your minds the extreme importance of this disease and its bearing upon the welfare of society in general.

In modern medicine the great slogan of the time is prevention, and in no instance is it more applicable than with trachoma. Here we have a contagious disease producing in every instance, all the way from slight impairment of vision to total blindness, yet we are not required to report it to the local or state authorities. Nor am I aware of any movement in the state whereby detailed ex-

aminations for the detection of trachoma are being made. This fact makes good food for reflection and we all should feel it incumbent upon ourselves individually and collectively to remedy the condition in this respect.

The responsibility for the detection of these cases rests on the general practitioner. If he is not acquainted with the disease he should feel it his duty to familiarize himself with trachoma, so he could at least make a tentative diagnosis; and all this amounts to is exposing the conjunctiva by everting the upper lids. Advanced cases of trachoma and cases with severe symptoms can easily be recognized by simple inspection. On the other hand, many apparently benign and quiescent cases present no easily recognizable external manifestations and can be detected only by everting the eyelids and exposing the conjunctiva.

From an epidemiological point of view, they are the most important cases because they are potentially a source of danger, yet are not readily recognized unless looked for in the manner described.

In 1897 the Secretary of the Treasury classified trachoma as a dangerous, contagious disease, and aliens arriving prior to this time were not deported. Thousands of cases were imported among arriving immigrants and it therefore becomes necessary to seek the foci of infection established by these cases and to stamp them out wherever found. Infected foci also receive additions through those who gain entry to the country in an illegitimate way. Over 30,000 desertions by foreign seamen are reported annually to the immigration authorities. A considerable percentage of the deserters who have been subsequently apprehended have been found afflicted with trachoma.

Owing to the findings of myself and two others, amongst the Indians of the United States, Congress, on August 24, 1912, made an appropriation of \$10,000 for the investigation of the prevalence of trachoma among the Indians. The examination was carried out by the Public Health Service and from 30 to 50% of the Indians examined were found affected. It was also found quite prevalent amongst the outside population in the vicinity of Indian reservations; in certain mining districts and amongst those living in the mountain ranges of Arkansas, Tennessee, Kentucky and West Virginia. There is an area in Southern Illinois called 'Little Egypt' on account of the great number of trachoma cases there.

I have examined some public schools in Indian countries and always found several cases of trachoma.

The negro is supposed to possess an immunity to trachoma, but I have seen some cases amongst the colored population. However, it is not common to see a negro with trachoma.

Trachoma is a dangerous, contagious, prevalent, preventable disease of the eye which has existed from time immemorial. It is essentially a chronic disease, but prone to remissions and exacerbations, and is characterized by an infiltration of the conjunctiva and conjunctival tissues with lymphoid elements with the formation of numerous elevations in the conjunctiva. After a varying time, from a few months to several years, this is replaced by scar tissue which has a marked tendency to contraction. There is more or less profuse discharge along with the conjunctivitis.

History—It is evident from ancient manuscripts that trachoma existed 3000 years ago and it is well described in Greek and Roman medical writings. The disease was originally found in Arabia and Egypt, where it was and still is very common among the population of all classes. It is so common, in fact, that nearly every person in Egypt is at some time affected with it in a mild or severe form. It is essentially a dirt disease, having its origin and best soil among them, in all countries where it exists, who live in unsanitary and filthy surroundings. It became disseminated in Europe when by reason of the Napoleonic wars the armies came so repeatedly in contact with each other and with the civil population. During the year of 1818, in the English army more than 5000 had been rendered blind as a consequence of trachoma. In the Prussian army in 1813 to 1817, 20,000 to 30,000 men were attacked with it. In the Russian army from 1816 to 1839, 76,811 men were subject to the disease. In Belgium, in 1840, one out of every five soldiers was affected with trachoma. Subsequently, these soldiers affected with eye diseases were discharged and in this way it became widely spread among the civil population. According to the descriptions of that time, trachoma ran a very acute course and was attended with profuse secretion, circumstances which explain the rapidity with which the disease spread. At the present time it is rare to see an acute case.

It exists extensively among certain classes of Hebrews, Italians, American Indians, Japanese, Chinese and other inhabitants of the Far East. It also prevails extensively among the Irish. Many immigrants are recruited from these classes.

Etiology—The cause is from the infectious, purulent secretion from a trachomatous eye. No specific micro-organism has been isolated. The infection is transferred from eyes of persons having this disease, affecting others by first touching their diseased

eyes and transferring the infectious material to towels, washing utensils, public seats, hand straps in streets cars, handkerchiefs, bed linen, money, etc. Flies also carry it.

Recent investigations have demonstrated an almost constant condition in the discharge and follicles of trachoma, very small diplobacteria always surrounded by a zone. These are styled "trachoma corpuscles." They are difficult to demonstrate and are believed to occupy a position morphologically between bacteria and protozoa.

During the past year a tiny Gram negative, strictly hemoglobinophilic bacillus was obtained in a large series of cases. They are antibiotic with certain streptococci which suggest an interesting line of investigations directed toward a rational treatment. This may explain the negative results often obtained in attempting to cultivate the organism from cases of trachoma. A more complete understanding of the bacteriology of trachoma will assist in formulating a rational prophylaxis and treatment of the disease.

Pathology—The anatomical changes in trachoma consist in an overgrowth of the tissues of the conjunctiva. The connective tissue forming a granule is stuffed full of round cells which causes elevations and corresponding clefts in the conjunctiva. This gives to the lid a mulberry appearance. It is difficult, if not impossible, to distinguish histologically between follicular conjunctivitis and trachoma. It is asserted upon good authority, that the difference is chiefly if not wholly, in the amount of material present in the two types. The trachomatous condition involves all parts of the conjunctiva, with the exception of the ocular part near the cornea and a narrow strip next to the lid borders. All these parts are usually covered by stratified squamous epithelium. The atrophic stage is marked by a disappearance of areas of the normal fibrous and elastic matrix of the conjunctiva along with the formation of connective or scar tissue.

As usually seen, the symptoms of trachoma are those of conjunctivitis. I have seen a number of cases in which the subjective manifestations were very mild and the eye clear and healthy in appearance, yet when the lids were everted they would be found loaded with granulations. These are not most dangerous cases and, unless they have a superadded infection or disturbance of vision, go untreated and unrecognized and thus serve as foci of infection to others. The majority of cases, however, sets in with moderate symptoms of irritation. The eyes burn and itch and have the sensation of particles of sand under the lids. The eyes are sensitive to the light and the lids appear heavy. In a typical

case there is lachrymation and a somewhat muco-purulent discharge. The eyelashes become matted together by the secretion and the lids have a tendency to stick to each other.

In the acute cases we have a violent ophthalmia with swelling of the lids, chemosis of the conjunctiva and profuse secretion. In fact we have the picture of a gonorrhoeal conjunctivitis. The inflammatory reaction may obscure the granulations, but as it subsides they come into view and have the appearance of grayish-pink spherical bodies about two millimeters in diameter, embedded in the conjunctiva.

After a varying period the follicles are thrown off or disappear by absorption with the formation of scars, the final stage. These scars have a special tendency to contraction as does cicatricial tissue elsewhere in the body. Because of this contraction and distortion of the tarsal plates the lashes are drawn in and rub on the eyeball producing the condition known as entropion. Other complications and sequelæ are pannus, trichiasis, symblepharon, xerosis conjunctiva and corneal opacities.

If seen early and treated properly and persistently we do not have these severe complications, but some damage to vision is almost inevitable. The great trouble is that persons having trachoma neglect the treatment or stop it too soon.

Treatment—Following out nature's method of cure I always advise operation by expression. For this purpose I use sand paper followed by the Knapp & Noyes's forceps. Following the operation to allay the reaction, hot applications are made to the eye for a period of half an hour. Then a drop of argyrol and castor oil is instilled. I continue the argyrol for a few days and then begin on the regular after treatment. This consists principally in the daily application of either the solid stick of copper sulphate or massage with protonuclein special. The copper is used for its stimulating and astringent properties. It should not be used with the idea of producing cauterization. This treatment must be long continued and the surgical measures may have to be repeated.

The complications require special attention and when we have iritis and corneal ulcers this requires the use of atropin and hot applications. The treatment is long drawn out, mild cases usually requiring months and the more severe types may take years. As a safeguard to the public health the treatment should in the main be prophylactic.

Since the number of cases among the school children would be a fair index of the extent of the disease among the population of a community, a detailed examination of public school children should be made at least once a year.

All cases of active trachoma should be excluded from the public schools.

Trachoma should be a notifiable disease and declared conditionally quarantinable, and sufficient funds provided in order that the cases which cannot be treated at home may be apprehended and treated at the expense of the state.

All cases of conjunctivitis should be excluded from school until such a time as recovery is complete.

The co-operation of all the mining companies of the state should be secured in the making of a detailed examination of the mining population for the detection of all the cases of trachoma among the miners employed by them. Miners suffering from trachoma should not be allowed to drift from one location to another unregulated and unrestricted. All miners suffering from trachoma should be compelled to undergo treatment under such restrictions as may insure safety to others. If necessary, this treatment should be at the state's expense, and be made mandatory.

—o—

THE FACT VERSUS THE MENTAL IMPRESSION.

DR. W. R. HEYLMUN, Iola, Kansas.

Read before the Southeast Kansas Medical Society Sept. 30, 1913.

It has been said that human knowledge is in part fact and in part theory. We, as physicians, have to deal with that form of knowledge wherein theory is a large element. Theory serves a good purpose as it often directs the investigator to the hidden fact. It is part of the business of physicians to study man; to learn by every possible means all that goes to make up his physical and psychic nature. If in our zeal we step beyond the bounds of fact into the realm of theory we are justified, so long as the fact and theory appear to agree with each other. You will, therefore, pardon me if an element of theory appears to constitute a large part of this paper. While the conclusions may not be new, I have been unable to find anything definite on the subject herein presented.

Protoplasm lies at the foundation of all life in this world, both animal and vegetable. Protoplasm is a proteid compound. It also contains inorganic substances as phosphorous and calcium. We may observe protoplasm both as a living and a dead substance. Living protoplasm is not life itself but is a substance charged with life force much as the loadstone is charged with magnetism. Protoplasm is the only substance of which we have any knowledge that takes up these life forces and becomes living matter. There

appears to be a wide difference in the quality of protoplasm, and likewise in the kind of life force with which it is charged. That which enters into the construction of the animal kingdom differs from that which goes to make up the vegetable kingdom; also that which goes to make up one part of the animal body differs from that which enters into the composition of other parts.

The protoplasm that appears to be the most highly sensitized and exhibits the highest qualities of life force is that which enters into the construction of certain portions of the brain. A cell is a certain quantity of protoplasm differentiated and organized into a dynamic unit. The fecundated ovum represents the highest type of cell unit as it holds within its microscopic body the promise of a living, sentient being, a being that is an elaboration of this primal cell. All nature is alive with vibrant energy and the animal has five protoplasmic centers each responding in its own way to that form of vibrant energy that reaches it through the channel that connects it with the outside world. While these centers, known as the special senses, respond to the effects of certain kinds of vibrant energy, thereby producing mental impressions, they do not convey to consciousness the thing as it is but an effect transformed by protoplasm into a mental impression of something that has no existence in fact. Consciousness has no possible means of knowing anything regarding its environments except what it obtains by way of the special sense. If the visual apparatus is out of commission, the person is blind and nothing appertaining to light can reach his consciousness. All the senses might be abolished, as in anæsthesia, and the person still live, but he would be as much shut out from the world as if he were dead.

Is the effulgence or luminosity that we regard as a necessary quality of radiant energy real or apparent? If real, this quality cannot pass through the opaque structure of the visual avenue between the retina and the sight center in the posterior part of the brain, therefore, if real it must be reproduced by the protoplasm that constitutes the sight center before it is perceived by consciousness. If it is not real, as it appears to be, then the effect of this radiant energy on the protoplasm of the sight center is to produce a condition, a molecular activity which is revealed to consciousness as luminosity with its accompanying shade and shadow, color and tint—the radiant energy exists without but those qualities that we attribute to it, effulgence, luminosity, color and tint, only exist within the brain. The retina of the eye is a wonderfully complex structure; its innumerable rods and cones are delicately attuned to every possible variation in which radiant energy may

reach it. The million or more insulated nerve fibres that enter into the structure of the optic nerve, convey as many different degrees or kinds of stimuli to the sight center with as many kinds of effect on its sensitive structure for consciousness to perceive.

I am of the opinion that luminosity and color are not properties belonging to radiant energy but are developed within the brain through its stimulating effect. The same thing applies to the other four senses, hearing, feeling, smelling and tasting; they are all the result of a certain stimuli acting on certain specialized protoplasm that is transmuted in the laboratories of the brain into impressions perceptible to consciousness.

I feel safe in asserting that the world we live in is absolutely dark, and absolutely silent, and that the effulgence of the day with its great display of color and tint, and all the sounds with which we are familiar, exist only in that great world of protoplasm that constitutes the essential part of the animal nature, the brain, and has no existence outside of animal consciousness.

—o—

Iodine forms a harmless soluble compound with phenols, and its affinity for phenol is very much greater than that for living protoplasm, hence its unique value for all forms of carbolic acid poisoning.—Medical Summary.

—o—

Death by Lightning—Jex-Blake states that persons struck and apparently killed by lightning should at once be given plenty of fresh air, their clothes should be loosened and artificial respiration by Schafer's or Sylvester's method should be applied and should be continued until either recovery occurs or cooling of the body and rigor mortis show conclusively that death has taken place.

—o—

Dr. Stark is emphatic in the belief that to give quinine to a person suffering from influenza, with severe headache, furred tongue and acute pain in the limbs, merely adds to his discomfort. He cuts the disease short in two days, he says, by giving a mercurial purge, followed by sodium salicylate, potassium bicarbonate and tincture of nux vomica.—"Practitioner."

—o—

Small epigastric herniæ, easily overlooked, are often the cause of pains in this region simulating those of stomach ulcer, gall-stones, etc. Some of these, however, consist only of properitoneal fat without any sac. The treatment of these latter by operation will not always relieve the pains for which a deeper source must, indeed, be sought.—American Journal Surgery.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,

-

-

-

-

EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor, Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS—President. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

New York City and Philadelphia, are having a severe epidemic of typhoid fever. So soon as the efficacy of typhoid vaccination shall have been established, this disease will disappear, as small-pox has diminished. Two other dreadful diseases however, have appeared which interfere with the annihilation of contagion and epidemics, viz., Christian Science and Chiropractic Numscullery.

—o—

The editor of the A. M. A. Journal, very aptly calls the attention of its readers to the misapprehension existing as to the cause of ochlesis, or crowd-poisoning, produced as was originally explained by the over-production of carbon-di-oxide and other poisonous gases, together with a diminished amount of oxygen in the apartments occupied, and cites the physiological experiment of a person breathing "pure" outdoor air through a tube, while his body is confined in a small chamber where the temperature and moisture are at a high degree; such conditions producing the same phenomena as those attributed to what has been commonly accepted as "breathing foul air." It would certainly offer the sanitary suggestion to managers of theatres, picture shows and like places, to so regulate their auditoriums, that low temperature and dryness shall exist to properly protect their patrons.

There is no doubt as to the efficacy of cool air and moving air, ventilation in the preservation of health and improvement in cases of ill health.

Inactivity is injudicious. Excessive warmth engenders it; cool air encourages the reserve.

—o—

According to published reports relative to the Panama-Pacific Exposition, those who attend may expect to be greeted, upon entering the grounds, with

"right this way ladies and gentlemen; come in and see
 "the most renowned professor; he can trim your corns
 "without pain (to him) and he's a dealer in magical spells,
 "in blessings and curses and ever filled purses, in pro-
 "phesy, witches and knells."

Passing along a little further you will be accosted by a representative of a book concern, and importuned to buy the most complete work on "How to Cure Yourself Without the Aid of your doctor." If you have already bought one of these, he will draw your attention to the latest book, entitled "Be Your Own Dentist" and will offer to throw in a magical mirror which will "enable you to fill your own teeth."

You then come to the only licensed spectacle booth on the grounds. Why consult your oculist when we can fit you to glasses better than he. Re-re-re-mem-ber, we pay \$60,000 for the exclusive right to sell specs at this memorable exposition where quackery in any form is "supposed not to exist."

Collier's Weekly has some very pertinent comments upon the subject of allowing quack commercialism to have any part in this exposition, commemorating as it does, the most important achievement of engineering in this century.

—o—

The following advertisements from the Cleveland Plain Dealer, August 23, 1913, appearing side by side would seem to show the class to which the "Chiros" belong. It also shows that the study of chiropractics is not one long, continuous grind, in fact, it would seem that the ultra-intelligent could successfully grasp the requirements in a very few years of constant application. Here is the clipping. Help!

CHIROPRACTIC DOCTORS MAKE BIG INCOMES; be independent, work for yourself; complete correspondence course, including diploma, only \$25. **NATIONAL COLLEGE CHIROPRACTIC,** Grand Rapids, Mich.

WANTED—Men to learn the barber trade; another rush for barbers this season; best trade in existence today; good money; light, clean, inside work; call at once or write Moler Barber College, 101 Prospect ave. N. W.

The Tenth Annual Session of the Clinical Congress of Surgeons will be held in Chicago, Nov. 10-15, inclusive. The program is complete in every particular and one need not have an idle moment during the meeting, such is the abundance of clinics. It is estimated that three thousand visitors will attend.

—o—

Here is an innovation that would be very practicable in other cities besides Fort Wayne:

The Wayne Pharmacy is the name of a new Ft. Wayne institution which has been established to do a prescription business and furnish supplies to physicians and hospitals. The institution is owned and controlled by over fifty physicians living in the city of Ft. Wayne who have decided to give their support to a pharmacy which will be strictly ethical in its conduct, carry nothing but the purest chemicals and drugs and the best of physicians' and hospital supplies, and under no consideration to carry or furnish patent medicines or do counter prescribing. The enterprise deserves success, and its patronage already indicates that the institution is appreciated by a large number of medical men.

—o—

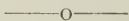
The Journal of the A. M. A., has been sued for libeling the Friedman "cure" for tuberculosis. The suit is brought in the name of one Dr. J. J. Meyer and is for the sum of \$100,000. The Journal is apparently not losing any sleep over the suit and they hardly need to as the concern exploiting the "cure" of which Dr. Meyer is a representative would hardly care to have the publicity of a trial. The Journal thinks the suit is all bluff and would be delighted with the opportunity of going to trial.

—o—

At the last meeting of the A. M. A., at Atlantic City, a committee was appointed, consisting of Barton Cooke Hirst, M. D., of Philadelphia; Robert L. Dickinson, M. D., of Brooklyn, and Joseph B. De Lee, M. D., of Chicago to investigate the treatment of puerperal fever. Letters of inquiry were sent to many prominent obstetricians, gynecologists and surgeons, both in this and foreign countries. Making their report which is published in the A. M. A., Journal for Oct. 25, '13, they came to the following conclusions:

The majority of accoucheurs and surgeons clean out the septic uterus at once, but a not negligible minority believe that it is safe to trust the expulsion of the infected uterine contents to the powers of Nature, some assisting the same by mild measures such as antiseptic douches and packing. From this it is fair to infer that, in the majority of cases, it has been found safe to invade the infected uterus with finger and curet, and this is borne out by experience. There are, however, many cases in which the infection is of such a nature, or the resistance of the patient of so poor a quality, that the sudden introduction into the system of so large an amount of bacteria and toxins, as is always made by curettage, turns the scale against the patient. She cannot stand the inoculation with autogenous vaccines. The experience of the minority has proved that ovular remnants, even though infected in the uterus, do not create such dangerous conditions as we for-

merly believed, demanding instant removal, but that it is safe to wait for Nature to erect her own barriers against the progress of the infection, and that temporizing measures, or mildly stimulating ones, often suffice for cure. We all feel the need of some method by which it would be possible to distinguish benign from virulent bacteria living in the genitalia, but as yet no such method exists. When it does become possible, our practice will become more definite. At present one-half of the authorities do not try to make the distinction, holding it impractical. One point that was almost invariably emphasized was that after the uterus was once emptied it should not again be invaded by either finger or curet. Few would permit antiseptic douches. This is a very grateful change from the time when repeated curettages were performed on the puerperal uterus—a procedure which was as rational as curetting the throat in diphtheria. Another interesting fact that was developed is that quite generally the tampon is used to stop the bleeding in infected cases. Evidently there is not much fear of damming back the infection and permitting greater absorption.



Good Roads Prevent Disease—Few persons, on first thought, would see any possible connection between good roads and good health. Yet the State Board of Health of Kansas says that good roads can and will prevent disease. How? By the removal of weeds and trash. Weeds and trash prevent the prompt evaporation of moisture and promote retention of ground water. This makes ideal breeding spots for mosquitoes, flies and other insects, which are known as disease carriers, not to mention chinch bugs, hoppers and other insects which are crop damagers. Furthermore, an undergrowth of weeds invites the dumping of garbage and manure by offering concealment, of which fact careless and thoughtless people are prone to take advantage, thus increasing the facility of insect breeding and providing these insect carriers with proper material for disease transmission. Good roads also prevent disease by providing good drainage. Many farms have no means of drainage except by ditches along roadways. Open ditches, clear of brush and debris, with hardened surface and proper fall, afford these farms the opportunity of ridding themselves of many a stagnant pool. The removal of weeds, proper road grading, surface hardening and oiling, insures prompt drainage of all pool, ditch and surface water, removing the possibility of insect breeders, for none can multiply without moisture. Road oiling in itself is destructive of insect larvæ, especially mosquitoes—a well-known fact. Dry roads offer pedestrians, and notably children who are compelled to walk to and from school, dry shoes and feet. While colds are due to specific germs, yet it is a well-known fact that cold, wet feet and chilled limbs lower the resistance of individuals and make them more favorable subjects for infections of the respiratory passages, including pneumonia and tuberculosis. Good roads prevent disease by setting an example to adjoining farm premises. Good roads promote travel and set an example to the farmer who premises are bordered by them. The comparison of a well-graded, clean highway with an unkempt and trashy barnyard adjoining is sufficient to stimulate every landowner to a clean-up. Pride compels him to offer to passers-by a neat-appearing and attractive house and barnyard. Results are only too obvious. Good roads are active disease prevention agencies, aside from their financial and commercial value.—*Journal A. M. A.*

It also might be said that good roads would help the health and disposition of a large number of physicians. It would then be some pleasure to make calls in the countryside in automobiles in place of ploughing through with two horse vehicles. It would get the physician to the bedside of patients with greater speed and far less discomfort. But then there are so many arguments for GOOD roads and none against that trypanosomiasis is the only reason that can be assigned for not building them years ago.

EDITORIAL CLIPPINGS.

A Clean Record in the Canal Zone—Those who have been following the remarkable record of the work of sanitation of the Isthmian canal, and have watched the gradual reduction of the death-rate and the elimination of preventable disease, have hoped that before the monumental work of constructing the canal was finished it might be possible for Colonel Gorgas to present a report that would be clean as far as death from disease was concerned. The report of the Department of Sanitation for the month of August, 1913, just received, shows that during that month there were thirty-nine deaths from all causes among the employees of the canal commissioners. Of these, one, a Peruvian, died of malaria; another, a Spaniard, of alcoholism, and the third, a Greek, of appendicitis. The only deaths among white Americans which occurred during the month were two from violence, one due to an accident on the railway and the other to an accident in the quarry. Among the 12,481 white American men, women and children on the Isthmus connected with the commission—that is, employees and their families—not a single death from disease occurred. The exodus from the Canal Zone has already begun; those employee whose work has been completed are returning to the United States with their families. The number of the American citizens resident in the Canal Zone will probably decrease steadily in the future. It is a fitting climax to the work of Colonel Gorgas, which has challenged the admiration of the civilized world, that the month which probably marks the high tide of American occupancy of the Canal Zone should have passed without a single death from disease in the American colony. —Journal A. M. A.

Too much praise can not be accorded Colonel Gorgas for his part in making it possible to bring to a successful conclusion the wonderful feat of connecting the Atlantic and the Pacific.

—o—

Limiting Enrollment at John Hopkins—It is an interesting fact that the Medical Department of the Johns Hopkins University has on account of limited space been obliged to announce that the enrollment must in the future be limited. The present year enrollment is 355; fifty students were refused because of lack of room. This seems to indicate that young men entering the medical profession are seeking the high class of schools. We have probably heard the last of the "poor young man" plea for cheap schools.—Journal of Iowa State Medical Society.

Eye Accidents in Golf—The ancient and honorable game of golf is not without its misfortunes to the eyes of its devotees. Many people have lost eyes because like Lot's wife they looked back. The familiar cry of "Fore" has been the signal for ocular destruction many times. When this imperative vocal signal reverbrates over the golf field, the first impulse of the average player is to look behind, and this is a fatal mistake, for, every once in a while, a ball strikes the eye, and it usually comes with so much force as to destroy the eye or seriously damage it. Vision, at least, is almost always lost, and the removal of the eyeball itself is frequently necessary to prevent a sympathetic and fatal disease of the other eye. The lesson to be learned is not to look back on the golf field. When "Fore" is called, look the other way, and lean forward, as it is better to be hit on any other part of the body than on the head. Even when "Fore" is not called, it is better not to look back, except when necessary, as balls are always liable to be flying (especially on small and crowded fields) and an eye injury is always among the possibilities.

Another, but less frequent, source of eye accidents on the golf field is the reckless and inconsiderate swinging of clubs in making practice shots when near other players. This is a common practice and should be sharply discouraged, as some fatal accidents have occurred by a crushing blow on the head by a golf stick. Eyes have been seriously and totally injured by the same custom. If players wish to make practice strokes they should do so in remote places where they will not injure other people.

Eyes are also frequently injured by being struck with foreign bodies, such as sand, gravel, etc., flying off from the end of a club, as when a player endeavors to drive a ball from a sand pit with a niblick. This exasperating performance will frequently be followed by a shower of sand, gravel, etc., flying around the players' head, and eyes are often injured in this way. The injury is usually slight, but sometimes more serious consequences ensue, and eyes have been lost from the consequences of such accidents.

Within the last two or three years quite a number of serious accidents have occurred from the opening of golf balls to ascertain their contents. Most balls contain no fluid, but there are balls wherein will be found acids, held there under high pressure, so that when opened by a knife, hatchet or what not, the acid squirts out. Not infrequently, the eyes and face have been severely burned. The acid is supposed to give the ball greater resiliency and carrying power, but its use is dangerous. Do not cut open golf balls, to see what they are made of, or for any other reason.—Journal A. M. A.

SOCIETY NOTES.

The first fall meeting of the Wyandotte County Medical Society was held at Kansas City, October 21st. Dr. C. J. Lidi-kay presented some eye cases.

Dr. L. S. Milne read a paper on the Benzol Treatment of Leukemia.

J. F. HASSIG, Secretary.

The annual meeting of the Medical Association of the Southwest was held at Kansas City, Mo., Oct. 7-8. The meeting was unusually successful. Clinics were held before and after the meeting. Many papers of exceeding scientific merit were read and discussed. The society was royally entertained by the physicians of Jackson County (Mo.) and Wyandotte County (Kans.) The following officers were elected:

President, Dr. S. S. Glasscock, Kansas City, Kansas; Vice-President, Dr. J. D. Griffith, Kansas City, Mo; Vice-President, Dr. J. D. Dodson, Vernon, Tex; Vice-President, Dr. D. A. Myers, Lawton, Okla; Vice-President, Dr. L. R. Ellis, Hot Springs, Ark; Secy-Treas., Dr. F. H. Clark, El Reno, Okla.

For members of the Executive Committee:

One year to fill vacancy, Dr. J. W. Duke, Guthrie, Okla.

For three years:

Dr. M. F. Jarrett, Fort Scott, Kans; Dr. A. L. Blesh, Okla. City, Okla; Dr. T. M. Paul, St. Joseph, Mo; Dr. J. E. Thompson, Galveston, Texas; Dr. St. Cloud Cooper, Fort Smith, Ark.

Officers of Sections—Surgery—Chairman, Dr. C. H. Cargile, Bentonville, Ark; Vice-Chairman, Dr. J. T. Axtell, Newton, Kans; Secretary, Dr. C. S. Venable, San Antonio, Tex.

General Medicine—Chairman, Dr. E. S. Lain, Okla. City, Okla; Vice Chairman, Dr. M. L. Perry, Parsons, Kans; Secretary, Dr. T. A. Jones, Liberal, Kans.

Ophthalmology and Oto-Laryngology—Chairman, J. S. Litchenburg, Kansas City, Mo; Vice-Chairman, Dr. C. L. Williams, Topeka, Kans; Secretary, Dr. J. H. Barnes, Enid, Okla.

The number registered as attending this meeting was 224 of which 60 were from Kansas City.

The Association unanimously voted to hold the next annual meeting at Galveston, Tex., and on account of the fact that early in Oct. the weather is quite warm in that city the meeting will be held either the last week in October or the first week in November

The Harvey County Medical Society varied its usual monthly program by taking as the general subject of its October meeting "The Professional Relations of the Physician with the Lawyer, Editor, Druggist and Preacher." The responses to the different parts of the topic were made by Clarence Spooner for the lawyer, Jesse L. Napier of the Newton Kansan for the press, J. B. Dickey the druggist, and Rev. J. B. McCuish for the clergy. These four with twenty-four doctors and five nurses from Bethel Hospital sat down to a bountiful supper at Unruh's Cafe at 6:30 p. m. The supper was followed by the addresses and a pleasant evening was spent. The towns represented by physicians were Newton, Halstead, Hesston, Sedgwick, Whitewater, Parkersville and Peabody. The Harvey County Society is a live wire of nearly thirty members and has monthly meetings well attended and profitable programs and discussions.

FRANK L. ABBEY, Secretary.

— o —

The Montgomery County Medical Society held its regular meeting at Coffeyville, Kansas, October 17th. The following program was given:

Typhoid Fever and its Prevention, Dr. W. H. Wells.

Operative Obstetrics, Dr. Wilhelm Fisher.

Surgical Treatment of Hernia, Dr. F. W. Duncan.

President's Address, Dr. J. H. Johnson.

— o —

The Labette County Medical Society met in Parsons, Wednesday the 22nd.

Dr. Hamill presented a baby with a large tumor of the back and a pronounced hydrocephalus.

Dr. Brady presented an old man with a well marked case of pellagra; the skin lesions, the persistent diarrhoea, loss of weight and emaciation, subnormal temperature, and mental depression were all present. No history of a corn diet could be obtained.

Drs. Rotter and Perry reported a case history and demonstrated a specimen showing a brain tumor occupying nearly all the right temporal lobe, the peculiar fact was that the tumor had produced so few symptoms that diagnosis of brain tumor had not been made.

Dr. Perry presented a specimen obtained from a case of pernicious anemia in which numerous saccules, some $\frac{3}{4}$ of an inch in diameter arising from the small intestine and extending up into the mesentery were demonstrated.

The main topic of the evening was typhoid. The following papers were given:

Prophylaxis, Dr. Cornell.

Diagnosis, Dr. Hamill.

Internal Treatment, Dr. Boardman.

Hydrotherapy, Dr. Brady.

Surgical Emergencies, Dr. Christman.

O. S. HUBBARD, Secretary.

—o—

One of the most successful meetings of the Northeast Kansas Medical Society was held at Leavenworth, Thursday October 30th. The meeting consisted of two sections, the first being from 1:30 until 6:00 p. m. During this session papers were read by Drs. J. C. Shaw of Holton Kansas, E. Smith of Lawrence, Kansas, C. L. Zugg of Kansas City, Kansas, L. F. Barney, Kansas City, Kansas; R. C. Lowman and Dr. McDougall of Kansas City, Kans.

The papers brought out earnest and logical discussion and were thoroughly enjoyed by some sixty (60) medical men in attendance. Recess was then taken and an elegant dinner partaken of by all those in attendance; served at Hotel Lindell.

At 7:30 p. m. the evening session began and the society was given a paper by Dr. Magee of Topeka.

We were then entertained by a talk on the hypophysis by Prof. John Sundwell of K. U., the professor held the members for some 45 minutes and was followed by Dr. P. T. Bohan, on Diagnosis and Treatment of Diseases of the Heart and for one hour and fifteen minutes the society was entertained by the Doctor who was in one of his happiest moods and his talk was thoroughly enjoyed by all present. The officers of the society wish to extend to everyone on the program their heartfelt thanks for the able manner in which they one and all, made the meeting of the society the most successful in its history.

The thanks of the society was voted to the Leavenworth County Medical Society for their splendid entertainment and to the Elks Club for the use of their palatial home—our meeting place.

C. C. GODDARD, Sec. Treas.

—o—

Half a hundred physicians from all over the Seventh district attended the annual fall session of the Medical society of the Seventh district held in the Commercial club rooms yesterday afternoon.

Medical terms marked by their longevity, and entirely meaningless to the vast multitude, who depend upon this class for restoration to health, flowed thick and fast from papers and in the

discussions following their reading. Some of these terms would certainly blank Noah Webster, himself, unless he had a physicians' guide to which he could refer.

Yesterday's meeting was marked by exceptionally good attendance and all those present declared it was very successful. The meeting opened with a business session.

W. E. Currie, Sterling; H. J. Duvall, Hutchinson, and W. F. Fee, Meade, who comprise the committee on constitution and by-laws, arrangements and programs, presented a constitution for the Seventh District society and this was adopted. The present organization was perfected at a meeting held last April and the above committee appointed to draw up the constitution. The meetings of the society are held semi-annually, the last Thursday in April and the last Thursday in October, and the election of officers comes in the spring.

Following are the officers of the organization: President, S. M. Colladay, Hutchinson; vice-president, W. F. Fee, Meade; second vice-president, C. Klippel, Hutchinson; secretary, W. F. Schoor, Hutchinson; Treasurer, T. A. Jones, Liberal. Dr. Klippel, presided at yesterday's meeting.

Papers were read by the following named doctors:

June M. Hull, Nickerson; E. E. Morrison, Great Bend; D. T. Muir, Alden; B. H. Pope, Turon; C. E. Fisher, Lyons; L. A. Webb, Stafford; M. Trueheart, Sterling; H. E. Haskins, Kingman. Discussions of the papers was led by the following doctors: W. H. Williamson, Hutchinson; C. Klippel, Hutchinson; J. E. Foltz, Hutchinson; H. S. Scales, Hutchinson; Monroe Jones, Hutchinson; C. E. Evans, Hutchinson; H. G. Welsh, Hutchinson, and R. Y. Jodes of Hutchinson.

As an enjoyable close to the meeting a banquet was held last night in the new Reno cafe, most of the doctors remaining for the spread, and of course Hutchinson's medical corps was out in full force.

Dr. C. Klippel presided as toastmaster and most of the toasts were in the nature of humorous stories, and doctors can tell 'em just as good as any one else.

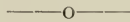
Toasts were responded to by the following named doctors: James A. Webb, Stafford; H. R. Ross, Sterling, who read from James Whitcomb Riley; H. E. Haskins, Kingman; H. G. Welsh, Hutchinson; W. Y. Morgan, Hutchinson; W. E. Currie, Sterling; W. F. Fee, Meade.

Dr. W. W. Pritchard of Bucklin, on the part of the visiting physicians, thanked the Hutchinson doctors for the fine manner

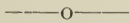
in which they entertained their guests. Dr. C. Klippel told the visitors the local doctors had enjoyed their presence here and that they are always welcome.

Besides the members of the society there were a number of visiting doctors at yesterday afternoon's session. Following are the doctors who registered:

William F. Fee, Meade; B. H. Pope, Turon; L. A. Bradbury, Lyons; Monroe Jones, Hutchinson; Hubert Fannon, Bucklin; A. R. Haas, Ellinwood; C. Kippel, Hutchinson; E. E. Morrison, Great Bend; C. W. Rairdon, Lewis; H. G. Welsh, Hutchinson; W. L. Butler, Stafford; Marion Russell, Great Bend; H. J. Duvall, Hutchinson; C. E. Phillips, Zenda; H. E. Haskins, Kingman; F. W. Koons, Nickerson; James A. Webb, Stafford; Charles Fisher, Lyons; L. A. Clary, Hutchinson; W. V. Elting, Burdette; W. F. Schoor, Hutchinson; June M. Hull, Nickerson; H. L. Scales, Hutchinson; C. Mayfield, Hutchinson; M. Trueheart, Sterling; T. J. Brown, Partridge; O. W. Sprouse, Inman; N. A. Seehorn, Hutchinson; W. E. Currie, Sterling; H. H. Heylman, Hutchinson; R. H. Ross, Sterling; J. E. Foltz, Hutchinson; J. J. Brownlee, Hutchinson; G. R. Gage, Hutchinson; Fred A. Forney, Hutchinson; F. E. Wallace, Chase; R. Y. Jones, Hutchinson; J. S. McBride, Lyons; P. A. Pearson, Kinsley; D. B. Buhler, Pretty Prairie; William Shull, Murdock; L. E. Vermillion, Lyons; M. C. Roberts, Hutchinson; C. S. Evans, Hutchinson; J. A. Dillon, Larned; T. L. Higginbottom, Liberal; W. W. Pritchard, Bucklin.—Hutchinson Gazette.

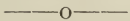


The Reno County Medical Society held its first meeting after the summer vacation, Friday evening, Sept. 26th. A rousing meeting was held in which all present took part in the discussion of the business of the medical profession of the county.

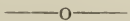


NEWS NOTES

Dr. and Mrs. H. S. Justice have gone to California for the winter



Dr. W. F. Schoor, city physician of Hutchinson, has fully recovered from a Colle's fracture, sustained by his car back-firing, while cranking.



Dr. G. A. Tull has moved from Clay Center to Boston, Mass.

Dr. O. D. Walker of Salina, councillor of the society from the 8th district was married October 9th to Miss Margaret M. Moore. Our best wishes.

—o—

B. L. Thompson, a butcher, of Harrington, James Campbell, a candy maker of Salina, and W. F. Jackson, Fort Scott, of the Bourbon County retailers, have been appointed advisory members of the State Board of Health to represent the merchants of the State and to aid the board especially as regards pure food matters.

—o—

Dr. W. K. Johnson, has moved from Hiattville to Piqua.

—o—

Dr. S. S. Glasscock of Kansas City, Kansas, was elected president of the medical association of the Southwest at their annual meeting held at Kansas City, Mo., in October.

—o—

The January meeting of the Council of the Kansas Medical Society will be held at Kansas City, Kansas, January 13th.

—o—

At the October meeting of the Board of Medical Examination and Registration held at Topeka, nine candidates successfully passed and three failed.

—o—

Case Reports.

I wish to report a rather unusual case of fracture, the only one of its kind I have encountered in a practice of twenty years.

Was called in consultation with Dr. Koons of this city to see a man 48 years of age, who had sustained an injury by being struck by the knee of a young horse while he was stooping in front of the animal.

There was a very distinct depression in the bone beneath the eye, and a space of at least three quarters of an inch where no orbital ridge could be detected.

Face was markedly asymmetrical, no crepitation nor movement could be elicited.

The cosmetic being the only condition that needed remedying, it was suggested that an effort be made to raise the depressed bones.

Suggestion was promptly vetoed by the patient, his argument being to let well enough alone.

A rather odd but amusing feature of the case was the ability of the man to inflate the whole side of his face with air when he attempted to blow his nose.

Crepitation produced by air in the tissues could be detected as far out as the ear on the affected side, the fracture no doubt communicated with the roof of the maxillary sinus, and the effort of blowing the nose forced the air through the natural opening in the antrum and thence into the surrounding tissues.

Trans-illumination of the antrum failed to show any effusion and the case went along without any ill results barring the asymmetry before mentioned.

This fracture could probably have been handled by the application of ordinary cow-horn forceps as used by the dentists, and which was illustrated in a recent edition of the American Medical Journal.

However, the text-books are very indefinite along the line of treatment of these fractures and no doubt the majority of physicians would be content as we were, to acquiesce with the wishes of the patient when he requested that it be left alone.

There was a slight mal-occlusion of the teeth on the affected side for a few weeks but not sufficient to alter the bite; this adjusted itself later into as perfect articulation as before the injury.

At present the cosmetic appearance is the only permanent ill result.—J. A. Dillon.

—o—

A Neosalvarsan Fatality—Referring to a recent editorial in The Journal commenting on an article by H. F. Swift (Oct. 5, 1912, p. 1236), M. E. Hagerty, St. Louis (Journal A. M. A., October 4), reports a case of death occurring after a second injection of neosalvarsan (0.6 gram) three weeks after a similar one which had caused no inconvenient symptoms. The full pathogenic report is appended, and the cause of death attributed by the pathologist was acute arsenical poisoning. This was the first fatality, occurring in Hagerty's practice in over 600 injections of salvarsan, but it is the seventh death of which he has knowledge resulting from salvarsan injection since its first therapeutic use in St. Louis.

—o—

REVIEWS.

In the Missouri State Medical Journal for October, 1913, is a very interesting and instructive article by E. B. Knerr, M. D., of Kansas City, Mo., on the treatment of Diabetes Mellitics, based upon the theory that every diabetic must have some carbohydrates continuously, and the carbohydrates ingested must be taken in such form as to be most slowly absorbed, and in his experience he has noted great and lasting improvement by feeding his patients raw starch and raw starch foods. Raw, green vegetables, raw

flour and raw corn starch. Uncooked, the starch grains are passed to the intestines and there are slowly digested and so slowly absorbed that the diabetic-weakened system can take care of them.

He gives case histories to verify his proceedings. His therapy outside of diet consists of citric acid and atropin.

In the International Journal of Surgery for August, 1913, Dr. M. F. Goldberger of New York, makes comparative argument in relation to trachelorrhaphy vs. amputation of the cervix for the cure of sterility, dysmenorrhea and leucorrhea. His summary of his paper is as follows:

(1) The diseased or abnormal cervix is one of the most frequent causes of sterility in the female. (2) When sterility is due to antelexion it is best corrected by the Dudley operation. (3) The dysmenorrhea is relieved in most cases following this operation and pregnancy occurs in 40 per cent of the cases. (4) Lacerations of the cervix should not be interfered with unless they cause definite symptoms, and then amputation seems to give the best results. (5) Erosions and ulcerations of the cervix not yielding readily to local medicinal treatment call for amputation as there is always fear of malignant degeneration. (6) If dysmenorrhea and leucorrhea be present in these cases, amputation of the cervix will relieve the pain and stop the discharge in about 80 per cent of the cases. (7) Labor seems to be rendered more difficult and prolonged in the cases following trachelorrhaphy and to be made easier and shortened after amputation. (8) Conception is just as frequent following amputation of the cervix as before.

MISCELLANEOUS.

AN EYEBALL OUT TO REPAIR IT.

W. L. Young Will Be Able to See After a Difficult Operation.

An operation on the eye of a man at the General Hospital this morning in which the eyeball practically was removed from its socket and replaced will be successful, according to the surgeons. W. L. Young, a carpenter, at 1003 East Fifth Street, was admitted to the hospital September 25 suffering from a growth in his left eye that had destroyed the sight. It was diagnosed as black cataract, a growth under the pupil inside of the eyeball. At first it strengthens the sight, focusing the light on to retina as a pair of glasses. Then it colors, shutting out all light. It was removed successfully this morning by physicians at the General

Hospital. The patient will be able to see now by wearing a strong lens over the eye which will take the place of the growth removed.—K. C. Star.

Too bad the operators name was not given. Since he is so successful at removing eyes and replacing them there is no telling to what extent he might benefit humanity by his handiwork.—Ed

—o—

TOO MANY KANSAS GINGER JAGS.

Druggists Who Sell Excessive Quantities Are to be Prosecuted.

Topeka, Oct. 25—The sale of Jamaica ginger in quantities which might indicate that the drug was to be used as a beverage will subject Kansas druggists to prosecution under the Prohibitory Law. That was the ruling of John S. Dawson, attorney general, today. There have been too many ginger jags in Kansas lately, he says.

"Jamiaca ginger contains 85 per cent alcohol," said the attorney general. "The ordinary dose is thirty drops. The ordinary purchaser of the drug would not buy more than an ounce or two of it to be used for ordinary medical purposes. Any druggist that sells this drug in large quantities to individuals at frequent intervals must take care to know just what it is being used for or he may find himself in jail as a jointist and punished for violating the Prohibitory Law."—K. C. Star.

—o—

New Medicos—We are now getting one new doctor a year for every 20,000 inhabitants. Twenty years ago one new medical man entered the field every year for each 14,000 persons. Sixty medical colleges in the United States have gone out of business in the past decade, and we now have but a few more than 100 left. Stricter laws regarding initial examinations of new doctors, stiffer and longer courses of study and a higher education demanded of students entering the medical course are some of the things which have tended to reduce the number of new physicians graduated every June.—Philadelphia Ledger.

—o—

R. C. Cabot gives the Diagnostic Pitfalls Identified During a Study of 8,000 Autopsies.—Some of the commoner mistakes:

"Acute gastritis" is a rare disease in adults. As a rule appendicitis or gall-stones is the correct diagnosis.

"Chronic indigestion" is usually a mistaken diagnosis, the acutal condition being peptic ulcer, pulmonary tuberculosis, constipation or cancer of the colon.

"Bronchitis" usually proves to be phthisis, bronchiectasis or bronchopneumonia at autopsy or in the outcome.

"Asthma" beginning after middle life is usually a symptom of cardiac or renal disease.

"Unresolved pneumonia" is frequently a mistaken diagnosis, the real disease being interlobar empyema.

"Malaria" is often given as the diagnosis in cases of phthisis, hepatic syphilis, hepatic abscess and urinary infections.

"Typhoid fever" in a patient's history may mean tuberculosis or latent sepsis (septic endocarditis, suppurative nephritis, etc.)

"Rheumatism" has sometimes turned out in my experience to mean, aortic aneurysm, cancer of the pleura, tabes dorsalis, osteomyelitis, spondylitis deformans, bone-tuberculosis, syphilitic periostitis, lead-poisoning, morphin habit, alcoholic neuritis, trichinosis and gonorrheal infection. "Rheumatism" is one of the most dangerous of all diagnoses to the conscientious physician.

"Cystitis" is usually a symptom, not a disease. It points to disease below the bladder (structure, obstructing prostate, etc.,) or above it (renal tuberculosis and other renal infections) as is the cause.

"Hemorrhoids" often mask cancer of the rectum.

"Neurasthenia." The real disease almost always shows itself in youth on the basis of congenital tendencies, though like tuberculosis it may be roused into active progress by any prolonged strain, mental or physical. When it appears after middle age it is almost always a symptom of organic disease such as dementia paralytica, chronic nephritis, arteriosclerosis, myxedema, hyperthyroidism or phthisis.

The incipient stages of the disease mentioned in the last sentence are rarely recognized. The same is true of gastric ulcer, pernicious anemia, leukemia, cirrhosis of the liver, congenital renal cysts, renal tuberculosis and many other diseases.

Cirrhosis was latent in patients dying from hyperthyroidism, cancer of the prostate, cancer of the rectum, cancer of the cecum, pancreatic cyst, pancreatic cancer, pneumonia after fracture of the femur, cut throat, aortic aneurysm, dementia paralytica, diabetes, hemophilia (no jaundice), and many other diseases.—Ohio State Medical Journal.

—O—

For Sale or Trade—Fine, modern, 10-room home for sale or trade for land; can be used as office and home. Good location for business. No competition near. Address L. C. R. % Journal.

Duty of Physician to Report Diseases—The physician is engaged in a work which places him in a position of especial and peculiar responsibility to the community, a work which carries with it moral and usually statutory obligations, on the proper fulfillment of which depends to a large degree the ability of the health department to perform its functions. The requiring of those desiring to practice to pass an examination and to be duly licensed and registered is a partial recognition of this, and presumably such licenses are given on the assumption that the recipient will comply with the requirements imposed on physicians by law, among which is invariably the duty of reporting cases of certain diseases coming to his knowledge. The physician who does not comply with such statutes not only places himself in the class of those who violate the law, but also shows himself indifferent to his moral obligations as they effect the welfare of the community. It would be well to give more definite recognition to the relationship the physician holds to the health department and to the community. Such recognition would undoubtedly be agreeable to physicians and bring them into closer cooperation with the health authorities in whose jurisdictions they practice.—Trask in *Public Health Representative*.

— o —

The Shocking Retort—We know a fine type of young practitioner who does a general practice. He has a unique way of receiving proposals from certain cultured married females among his clientele.

Mrs. Brooke-Jones trips gracefully into the Doctors' consulting room, lowers her eyes, blushes just a wee trifle and observes: "Well, Doctor, here I am again. It's humiliating. I can't let it go on. Why, Gerald is only fourteen months old and Burton is not three yet!"

"Is it possible?" murmurs the doctor sympathetically, patting her hand like an old school gentleman.

"Yes," continues the distressed matron, her eyes filling with tears. "I told Henry I simply couldn't go through it again. My friends are commiserating me as it is, and another so soon would be scandalous!"

"There, there," purrs the young doctor. "And what can I do for you, Mrs. Brooke-Jones?"

"Give me something or other to bring on my period."

"What! You ask me to destroy life?"

"Oh, pshaw, I've only skipped two periods. Surely——"

"Wait, Mrs. Brooke-Jones, pardon me. It would be a great

risk—for you, I mean. You might suffer blood-poisoning and death from such interference. But I think I can assist you — you're perfectly well in every way are you not?"

"Yes, indeed—everything but—"

"And your only reason for wishing this abortion is that you don't want more than two children?"

"Yes, I think two are enough."

"Very well, Mrs. Brooke-Jones," suggests the doctor calmly. "As I said, I don't like to risk two lives—your unborn child's and your own—but I don't mind committing one murder for friendship's sake, you understand—do you?"

"I understand," smiles the eager visitor, "—only you needn't be so terribly serious about it. All the women I know—"

The doctor breaks in. "Now, I'll tell you what I'll do. Just let Nature alone and keep your good health. But bring me either of the other children—I don't care which—and I'll butcher him for you. That will save risking your own life and—"

Mrs. Brooke-Jones rises indignantly and marches out. A few months later, as a rule, the doctor ushers the bone of contention into a happy home.

Mother-love is an animal instinct.—St. Louis Medical Review.

—o—

The following toast "The Brother I'll Never Know," was delivered before the Iroquois-Ford Bi-County Medical Society, by Dr. J. L. Shawl:

"Here is a toast I want to drink
To the brother I'll never know,
To the brother who's going to take my place
When it's time for me to go.
I've wondered what kind of a chap he'll be,
And I wish I could take his hand,
Just to whisper, 'I wish you well, my brother,'
In a way he'd understand;
I'd like to give him the cheering word
That I've longed at times to hear;
I'd like to give him the warm hand clasp
Whenever a friend seemed near.
I've learned my knowledge by sheer hard work,
And I wish I could pass it on
To the fellow who'll come to take my place
Some day when I am gone.
Will he see all the sad mistakes I've made
And note all the battles lost?

Will he ever guess the tears they caused
Or the heartaches which they cost?
Will he gaze through failures and fruitless toil
To the underlying plan,
And catch a glimpse of the real intent
And the heart of the vanquished man?
I dare to hope he may pass some day
As he toils as I have wrought,
And gain some strength for this weary task
From the battles I have fought.
But I've only the task itself to leave
With the cares for him to face,
And never a cheering word may speak
To the fellow who'll take my place.
Then here's to your health, old chap,
I drink as a bridegroom to his bride,
I leave an unfinished task to you,
But God knows how I've tried.
I've dreamed my dreams as all men do,
But never a one came true,
And my prayer tonight is that all the dreams
May be realized by you.
And we'll meet some day in the Great Unknown
Out in the realm of space;
You'll know my clasp as I take your hand
And gaze in your tired face.
Then all our failures will be success
In the light of the new found dawn,
So I'm drinking your health, old chap,
Who'll take my place when I'm gone."

—o—

An Editor's Savings—An editor who started about twenty years ago with only fifty-five cents is now worth \$100,000. His accumulation of wealth is owing to his frugality, good habits, strict attention to business, and the fact that an uncle died and left him \$99,999.—Editor and Publisher.

—o—

What is Courage?—The bravest men are not those who are insensible to physical fear, but those who master it by courage of spirit; the purest and noblest are not those who have never felt the temptations of the body, but those who have resisted them.—
The Outlook.

A Hospital Record—Here is an entry from the records of the Kansas City General Hospital, regarding a recent woman patient:

Woman 30 years old; mentally unbalanced; baby born at hospital May 5. Investigation showed this woman was once adjudged insane in Iowa and was committed to state hospital. She was discharged, married, and had three children before coming to Kansas City. Two of these are now in a school for feeble-minded in Iowa, the third is with a home-finding society. Her husband deserted her. After the birth of the baby here the woman became violently insane and was returned to Iowa. The baby is still at the hospital.

These four children, all of them probably feeble-minded, will be allowed to grow up to rear feeble-minded families in their turn, and their children to rear more feeble-minded families, and so on—unless society becomes sufficiently civilized meanwhile to put a stop to this sort of misery.—Kansas City Star.

—o—

CLINICAL NOTES

SURGICAL SUGGESTIONS FROM AMERICAN JOURNAL OF SURGERY.

The employment of narcosis in a case of "stiff and painful shoulder" may reveal a cause not otherwise ascertainable, e. g., subluxation.

—————

Vein-to-vein transfusion possesses over the artery-to-vein operation at least the advantage of sparing the donor a conspicuous scar and the loss of a large artery. With a tourniquet lightly applied to his arm the venous pressure may be made abundant, and the blood flow correspondingly rapid.

—————

The long-used term "congenital hernia," for that variety in which the testicle lies in the sac, is misleading insofar as it suggests that all the other varieties are not congenital. Many types of inguinal hernia are congenital, perhaps all are.

—————

In lumbar kidney operations take pains to protect the iliohypogastric nerve. Its division causes paralysis of a considerable area of the abdominal wall and produces a distressing pseudo-hernia. If the nerve is divided in the operation suture it.

—————

To encourage the drainage of pus from the pelvis through an abdominal wound, it is helpful to have the patient lie face downward at intervals, preferably with the foot of the bed elevated—but not until two or three days after the operation.

THE JOURNAL

OF THE

Kansas Medical Society.

Vol. XIII.

KANSAS CITY, KANSAS, DEC. 1913.

No. 12

THE BENZOL TREATMENT OF LEUKAEMIA.

LINDSAY S. MILNE, M. D., Kansas City.

Read before the Wyandotte County Medical Society, October 21, 1913.

The subject of this paper has reference to the treatment of that rare but very interesting disease, leukaemia. Usually one is only a more or less inert spectator of the progressive course of this disease to a fatal termination. Any method, then, said to influence these cases beneficially might well bear some consideration, and should we find any treatment which will prove of real value, then a distinct step has been achieved in therapeutic medicine.

Very few measures are known to be of service in leukaemia. Many of such cases from time to time temporarily improve with no treatment at all. Arsenic has been used with, at the best, only doubtful results.

X-rays have been extensively used and until recently this has been the only method at our command which really influenced the course of the disease. By this means the leucocyte count can be markedly reduced, the spleen becomes smaller, and the patient may feel his general health much improved. This method, however, is very expensive and very inconvenient. It is also very slow, requiring many months before any marked results are obtained, and they are very uncertain. In practically every case only very temporary benefits are derived from it, and a case once treated by X-rays and which has relapsed, very usually does not respond well to a second course of treatment.

Recently injection of Thorium X (radium bromide) .2 to .6 mg. have also been used with, on the whole, beneficial results, yet this method of treatment is very expensive and has no particular advantage over X-rays.

Benzol as a method of treatment in leukaemia was first suggested by v. Koryáni in 1912. He was induced to do so as the result of watching the effects of benzol poisoning in girls in a factory where benzol was used as a solvent for rubber cement in the manufacture of tin cans. The girls all developed a marked aplastic anaemia with a particular reduction in the number of the leucocytes in the blood.

During the past year a considerable number of observations on the effect of benzol in leukaemia have been published. The more important of these and their results are noted in the following table:

Results of Treatment of Leukaemia Cases With Benzol.

	Duration of						
	W.B.C.	R.B.C.	Hb.	treatment	W.B.C.	R.B.C.	Hb.
Koryáni (Berl.Klin.Woch.1912 : XXIX :135)	220,000	3,100,000	70%	5 mos.	12,000	4,000,000	....
Kerályi (7 cases)	131,000	.....	....	3 wks.	7,200	.....	....
(Wien.Klin.Woch.1912 : XXXV :1311)	140,000	.....	....	3 wks.	15,000	.....	....
Stein (Wien.Klin.Woch.1912 : XXV :1909)	225,000	2,800,000	60%	40 das.	6,000	3,500,000	68%
Eppinger (Verl.d.Wien.Med.Ges. 1912 : No 6)	300,000	.....	....	2-3 mos.	7,000	.....	....
Kovács (Königh.Ges.d.Aerzte. Budapest.1912 :No 30)	350,000	.....	....	2-3 mos.	12,000	.....	....
Billings I	190,000	4,100,000	68%	6 wks.	3,600	4,960,000	85%
II	143,000	3,860,000	63%	2 mos.	40,000	.....	....
III	47,000	.....	....	2 mos.	9,800	.....	....
IV	576,000	2,840,000	50%	7 wks.	8,500	4,100,000	60%
V	45,000	.....	....	60 das.	5,800	.....	....
(Jl.A.M.A. 1913 : LX :495)							
Wachtel (Deut.Med.Woch.1913 : VII :307)	182,000	3,695,000	67%	4 mos.	13,000	4,314,000	76%
Stern (Wien.Klin.Woch.1913 : XXVI :365)	204,000	.....	....	2-3 mos.	11,000	.....	....
Tadesco (Wien.Med.Woch.1913 : Sohn.	120,000	.....	....	2-3 mos.	11,000	.....	....
XXVI :375)	149,600	3,800,000	....	3 wks.	206,000	2,120,000	....
Rösler I (Wien.Klin.Woch.1913 : XXVI :375)	200,000	5,120,000	81%	4 mos.	72,000	6,400,000	95%
(Berl.Klin.Woch.1913 : XXVI :838)							
Rösler II	237,000	.....	....	63 das.	26,400	5,200,000	100%

Most of these cases were myelogenous leukaemias, yet some were of the lymphatic type and in both of these varieties the benzol seemed to act equally well. They all show that benzol in

a comparatively short period of time profoundly altered the blood count. With one exception, that of Sohn, the authors were enthusiastic about the remedy. The patients all felt better and their leucocytes became reduced in number. In many, X-rays had also previously been used for varying periods with more or less inconspicuous results. With such a record this method is indeed worthy of investigation.

The usual method of administering benzol is by the mouth, given in capsules and made up with equal parts of olive oil. It is best given along with a glass of milk, or after a meal, as there is less tendency to burning sensations which are not uncommonly experienced if the benzol is taken on an empty stomach. Also along with olive oil, benzol is much less irritating. Most commonly the dose is begun at about half a cubic centimeter to one cubic centimeter of benzol a day, increasing this to, in some cases, as much as four cubic centimeters a day. In doses higher than this untoward results may be expected.

As regards symptoms, usually none are complained of except perhaps the unpleasant odor of the benzol. Sometimes there are gasoline tasting eructations and burning sensations in the stomach. Some few cases vomit after every administration of the drug, others simply may be nauseated. Dizziness or slight headache are occasionally complained of and in one reported case there was a diffuse skin erythema. I have tried this method of treatment in seven cases of leukaemia, but in only three of them has the treatment been able to be continued for a sufficient length of time to draw any conclusions. One of these cases was unable to take the benzol even in very small quantities, as she vomited after every dose.

Case I, one of myelogenous leukaemia, for the records of which I am indebted to Dr. Murphy, occurred in a woman 28 years of age. She was well developed, married, but had never been pregnant, and has had no other illness besides her present condition. She had come under observation for rheumatism which, along with marked general weakness, had commenced about one year previously. At this time her spleen was found markedly enlarged and her leucocytes numbered 200,000 per cubic millimeter. During the next two years she was extensively treated with X-rays and her general health considerably improved. The spleen became somewhat reduced in size and the leucocytes towards the end of this time fell to 60,000 per cubic millimeter. Soon after discontinuing the X-rays she became

very weak, the spleen enlarged and the leucocyte count again became very high.

On September 20, 1912, she was put on benzol 3 c. c. and later to 5 c. c. daily. The following chart shows the very characteristic action of benzol on the blood count:

Date.	Leucocytes.	Erythrocytes.	Haemoglobin.
September 20, 1912.....	145,000	3,190,000	60%
September 23, 1912.....	150,000	.....	....
September 27, 1912.....	142,000	3,600,000	62%
October 1, 1912.....	152,000	.....	....
October 3, 1912.....	251,500	.....	....
October 5, 1912.....	230,000	3,750,000	65%
October 7, 1912.....	208,000	.....	....
October 9, 1912.....	220,000	.....	....
October 12, 1912.....	325,000	4,000,000	70%
October 14, 1912.....	350,000	.....	....
October 17, 1912.....	297,000	.....	....
October 21, 1912.....	275,000	4,150,000	75%
October 25, 1912.....	295,000	.....	....
October 27, 1912.....	237,000	.....	....
October 29, 1912.....	175,000	4,225,000	80%
November 1, 1912.....	212,000	.....	....
November 6, 1912.....	175,000	4,300,000	82%
November 10, 1912.....	150,000	.....	....
November 16, 1912.....	120,000	4,500,000	85%
November 21, 1912.....	87,000	.....	....
December 1, 1912.....	90,000	4,700,000	87%
December 6, 1912.....	62,000	.....	....
December 12, 1912.....	37,000	4,900,000	96%

As is usual in cases receiving the dose she was getting, the count at first rose as if the drug stimulated the formation of more leucocytes. In three weeks the count numbered more than double than when the treatment was commenced. At this time, however, she felt improved in general condition, was distinctly stronger, and had a much better appetite. Her only complaint, besides occasional headache, was the belching up of gasoline smelling wind. Her spleen had already become somewhat smaller and the erythrocyte and haemoglobin count had begun to rise. During the next two months the leucocyte count steadily fell and the red corpuscles and haemoglobin rose till the blood picture eventually assumed relatively normal proportions. At the end of this time, December 12, 1912, the spleen was reduced by half, having receded from the brim of the pelvis to the level of the umbilicus. She also felt very well, and treatment was discontinued. Shortly after this she had some domestic trouble and she developed a mild grade of melancholic insanity from

which she completely recovered in about a month. Since then she has been working in a telephone exchange and feeling in the best of health. In the past few months, however, the leucocyte count has again risen and the red corpuscles and haemoglobin have fallen. On June 15, 1913, the leucocytes had again become increased to 167,000, the erythrocytes had fallen to 2,600,000, and the haemoglobin to 45 per cent. Benzol was recommended at this date and on July 11, 1913, a little over one month, the leucocytes numbered 73,000, erythrocytes 3,600,000 and haemoglobin 58 per cent.

Case II illustrates another mode of action of benzol in leukaemia. It occurred in a woman 30 years of age. She was unmarried and had an exceptionally good family history. About a year before she first came under observation she began to get very weak and she frequently became nauseated and vomited after meals. Her appetite was very poor and she was very constipated. During the previous four years she had often complained of headache and dizziness, and she occasionally had some running from the right ear. During the last two months of this time her eyesight had failed markedly, so that she could do little more than see enough to get around.

Her eyes presented the picture of a marked leukaemic retinitis. She was well developed and fairly well nourished. The spleen was markedly enlarged, extending about one inch below the level of the umbilicus. The liver also was markedly enlarged. The urine showed no important change. The blood count showed the typical picture of a myelogenous leukaemia, the leucocytes numbering 121,000 per cubic millimeter.

On April 1st she was put on 4 c. c. benzol daily. She complained of no stomach trouble while taking this; indeed, the nausea and vomiting of which she had previously often complained, occurred less frequently. Her eyesight when the benzol was started was reduced so that she could not read any kind of print, but in the next few weeks rapidly became worse. The retinal vessels seemed to become more congested and the haemorrhages round the macular region more evident. Benzol was given till May 19th, about seven weeks, and discontinued then as her eyesight had become worse. The leucocytes, as is seen in the following record, had fallen to 23,000 and the erythrocytes had risen from 3,680,000 to 4,850,000. The haemoglobin had also risen from 45 per cent to 90 per cent:

Date.	Leucocytes.	Erythrocytes.	Haemoglobin.
April 1, 1913.....	121,500	3,680,000	45%
April 8, 1913.....	112,500	.....	....
April 12, 1913.....	112,200	.....	....
April 19, 1913.....	109,800	.....	....
April 25, 1913.....	75,000	3,680,000	60%
April 30, 1913.....	80,000	.....	....
May 5, 1913.....	72,000	4,630,000	75%
May 12, 1913.....	59,000	4,920,000	80%
May 19, 1913.....	23,600	4,850,000	90%
May 27, 1913.....	14,600	5,380,000	95%
June 9, 1913.....	12,300	.....	....
June 18, 1913.....	8,200	6,030,000	76%
June 30, 1913.....	16,200	5,430,000	80%
July 22, 1913.....	19,400	6,230,000	65%
August 25, 1913.....	18,200	4,820,000	68%
September 17, 1913....	22,000	.....	....
October 13, 1913.....	36,800	2,600,000	41%

In this case, different from the first case, and from the usual result, there was no preliminary rise in the number of leucocytes. Instead there was a progressive and rapid reduction. During the next three weeks after treatment had been discontinued the leucocyte count continued falling till it became normal. At this time the spleen had receded about four inches till it could just be felt under the ribs. With the exception of her poor eyesight she felt extremely well. Her appetite was very good and she was very much stronger than before. During the next few months the leukaemic condition had recurred to some extent although at the present time she still feels very well. She has, however, developed a complete optic atrophy. How far the benzol contributed to this it is difficult to say. She had a pronounced neuroretinitis before the treatment was commenced, and also in no other cases treated in this way, nor in the experimental work I have done in dogs, has any such condition developed.

Case III occurred in a well developed man, age 21. He had been working until five days before coming to hospital. Before this he had felt fairly well except for slight shortness of breath on heavy exertion. He had also noticed when he had whooping cough a year before that he had at that time a lump in the upper part of his abdomen. This lump had been growing larger and on examination proved to be the spleen. He came to hospital on account of a very acute pain over the region of the spleen which had lasted for five days. His abdomen was held very rigid and he felt very nauseated. This evidently was the result of an infarction or hemorrhage in his spleen and after three days

in the hospital his pain entirely disappeared. He was put on benzol May 15, 1913, at which time his leucocytes were estimated at 193,800 and showing all the variety of types peculiar to myelogenous leukaemia. The treatment was carried on for the next six weeks during which time the leucocytes rose to almost twice what they originally were, then rapidly fell. The red cell count and haemoglobin rose, however.

Date.	Leucocytes.	Erythrocytes.	Haemoglobin.
May 15, 1913.....	193,800	3,384,000	56%
May 17, 1913.....	213,200	.....	.....
May 19, 1913.....	269,000	.....	.....
May 22, 1913.....	231,200	3,225,000	60%
May 26, 1913.....	258,000	.....	.....
June 5, 1913.....	330,000	2,672,000	45%
June 11, 1913.....	260,000	.....	.....
June 17, 1913.....	228,000	3,424,000	55%
June 19, 1913.....	222,400	3,832,000	60%
June 25, 1913.....	169,000	4,100,000	62%

The spleen was originally down to the pelvic brim, but after six weeks' treatment was only down to the level of the umbilicus and not nearly so hard. The rapidity with which the spleen receded in this case was remarkable. Treatment was discontinued June 25th, at which time he went home as he felt entirely well. Two months later, while taking no treatment of any sort, he reported as still feeling well.

In these three cases, as in four others which received benzol for a short period there were no particular symptoms complained of save occasionally some burning sensations in the stomach. If, however, the benzol is given in capsules with olive oil and along with milk or just after a meal, very few stomach symptoms are apt to be complained of.

In small doses benzol seems to stimulate the blood forming tissues, both leucocytes and erythrocytes increasing in number. If these small doses are persisted in for some time the leucoblastic tissues get worn out and the leucocytes decrease. At the same time, however, the erythroblastic tissues still keep on proliferating and the red cell count keeps increasing. In larger doses the leucocytes may diminish from the first and yet the red cells increase. In very large doses both leucocytes and erythrocytes rapidly decrease and the bone marrow becomes quite aplastic.

Experimentally much the same results have been obtained as is shown by the works of several observers. My own experiments on rabbits and dogs also show that by the administration

of benzol in small doses both the erythrocyte and leucocyte counts are raised, and, if this be continued for some time the leucocytes will be reduced in number and the erythrocyte count may stay at a high figure. In some of my dogs the erythrocyte count has been raised from 5,000,000 per cubic millimeter to 12,000,000 or more, and the leucocytes to 16,000. Later, in about four or five weeks, in dogs getting 3 c. c. benzol by the mouth, while the red count still remains high the leucocytes fell to 5,000 or lower. Where four to five cubic centimeters of benzol are given, the rise is more rapid and the fall in the leucocytes occurs correspondingly early. Where considerable larger doses than this are given, particularly in young dogs, both leucocytes and erythrocytes fall rapidly and the animal may die with intense fatty degeneration of the organs and a marked aplastic anaemia. Dogs stand this benzol treatment very well, even in large doses. It apparently does not have any serious effect on their general health and their appetite and digestion remain good. In rabbits these changes in the blood count are more readily seen. Injected hypodermically in much smaller doses than usually produce no effect when given by the mouth, the most severe results are apt to be obtained. Half a cubic centimeter hypodermically in rabbits produces the same results as three or four cubic centimeters by the mouth and tends to produce a severe reduction in all the blood elements.

When administered by the mouth to normal individuals in the usual doses given to leukaemia cases, two to three cubic centimeters daily, very little effect is usually produced. Their digestion does not suffer in any way and their blood shows only a slight increase in leucocytes and erythrocytes at first, with a subsequent decrease in leucocytes in a month or two, to about four or five thousand per cubic millimeter.

There seems to be very little danger attached to the administration of this drug, if given in moderate doses. In larger doses it is a severe poison rapidly destroying the blood cells and the blood forming tissues. In most of the reported cases no serious effects resulted. In two of my cases untoward symptoms did occur, but their relation to the benzol treatment was doubtful. In the first case some little time after the benzol was discontinued the woman developed a mild melancholia, which, however, might well be accounted for in other ways. The second represented rather a real danger in that the neuroretinitis which she presented, apparently progressed rapidly while she was under the influence of benzol.

It would seem then that benzol is better avoided in the treatment of leukaemia when the case is a very acute one, with fever and a very high count, also in very nervous subjects and particularly in cases which have a high degree of leukaemic retinitis, a condition which is not particularly uncommon in leukaemia.

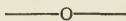
Benzol seems to act equally well in lymphatic types as in the myelogenous varieties of leukaemia. It destroys the degenerate and newly formed leucocytes of all varieties in the blood. During the administration of benzol the blood picture shows great disintegration of all the leucocytes, particularly the myelocytes. In the early stages numerous unformed, newly developed myelocytes appear in the blood and later these become disintegrated and disappear. Numerous nucleated red corpuscles appear in the blood in the early stages, especially when fairly large doses are given and the bone marrow and other blood forming tissues are actively stimulated to proliferation.

It acts therefore in leukaemia by destroying the leucocytes circulating in the blood stream and by preventing the leucoblastic tissues from forming any new cells. In the same moderate doses, however, it stimulates the erythrocyte formation and so tends to increase the red cell and haemoglobin counts. It does not act against the cause of the leukaemia, whatever that is, although that might be suggested by the enormously improved general health of the patient. It is not a definitely curative agent, and at the best the course of the disease is only arrested. The bulk of cases seem eventually to relapse after the benzol is discontinued. There may, however, be quite a long interval when the patient's blood count is almost normal, his spleen and lymphatic glands much reduced in size or normal, and the general health excellent. When the leucocyte count again rises, benzol treatment may again be equally effective.

In pernicious anaemia also, benzol seems to have some field of usefulness. In many such cases purgation, arsenic, and other remedies having failed, benzol in small doses, about one cubic centimeter a day, in some cases seems to be able to considerably increase the red cell count. In one case I have tried this with very encouraging results, although it is uncertain how permanent this increase will be.

This method of treatment in leukaemia, admittedly by no means ideal, and although undoubtedly some more efficient remedy will be discovered, has proved a wide and interesting field for experimental and therapeutic investigation, and has

given us a method by which we can profoundly affect this disease, generally in a more beneficial way than any other at present at our command.



IRRESPONSIBLE MEDICINE.

DR. NOAH HAYES, Seneca, Kansas.

Read before the Nemaha County Medical Society, Oct. 30, 1913.

In support of this preamble and resolutions* I ask your kindness and sympathy in trying to emphasize some universally admitted truths in support of them.

When the great Hippocrates appeared on the scene, Greece was studded with costly and beautiful shrines to Esculapius, the God of the healing art. He was apprehended as a destroying, yet appeasable, deity. Pestilence and death from an unseen cause, and the joy and beauty of health, were traced to him. Whatever happiness here or hereafter the worshiper aspired to, he sought it through maintaining the youthful vigor, symmetry, and beauty of the body; and social science and reforms of all kinds clearly indicate that we are fast returning to the old Greek reverence for the body being as sacred as the soul, whose temple it is.

Belief in Medicine is Natural.—From Hottentot to Huxley and the Pope, man cherishes a common belief in a future life where there shall be no painful perturbation. This universal faith of man's religious nature is paralleled by his belief in the efficacy of medicine, in its broad sense, for the many ailments of mind and body that come upon him; and it would not be a departure from his customary way of reasoning to say that the universality of this belief is convincing evidence that it is well founded.

We Should Protect the Buyer From His Mistaken Notions.—But because the layman has no practical knowledge of most medicines, his inability to differentiate the irresponsible hand that proffers them must continue for a long time to come. His inability is our responsibility; and we may not fall short of its full discharge and escape dire consequences to ourselves, because we would fail to render unto him that which is his due. Hence it is that the practice of medicine demands that physicians move upon the highest moral and spiritual plane to which humanity has the power to ascend.

What Medicine is Doing.—Faith and hope are our common

*Resolutions appear immediately following article.

heritage, but rational medicine, founded upon the natural sciences, is tirelessly sculpturing the supreme virtue, charity; with due reverence for the body she is moving humanity forward to a life of health, happiness and peace on earth. (Thy will be done on **earth**.) And this work is advanced by holding to the world-old humanities; old but new, and plain, and necessary; new as daylight, or as food to the hungry. Its creed is "A neighbor's need is the measure of a man's duty."

Our Duty.—The day's work for us is to purify ourselves of this hideous patent medicine obsession. Only by this shall we acquire authority and power to pull down other false gods to whose shrines the victim of disease hitherto brings his votive offerings. Patent medicine exploiters are not only inimical to all that is best in human life, they are the enemies of our own household; vermin which have attached themselves to us; we harbor and nourish them when we patronize the medical journals that help to keep them alive.

Legislation Not Yet Needed.—We are not ready for more restrictive laws. In the nature of things all statutory laws are a little lower in reason and morals than the average constituent of the legislature that enacts the laws. Hence it is that we must reform ourselves before we can have laws to aid us in the reform of others. Either we shall eradicate this evil or we shall forfeit our right to the distinction of a learned profession. For erudition must henceforth have additional meaning, and stand for wisdom and goodness as well as for learning and knowledge.

If we come with clean hands to the duty of getting favorable laws; if we refuse longer to be a party to the murderous traffic in nostrums; then we shall be able to secure legislation requiring the applicant for license to pass an examination in such of the natural sciences as are fundamental in the equipment of a responsible Doctor of Medicine.

We do not need medical "literature" that fattens on blood money, its income wrung from the betrayed, poor, sick people; in return for whose faith and hope, time and money, they hand out deception and injury, thus feasting on the very lives of their victims.

When shall the medical profession cease to be largely responsible for this lowest of crimes?

What We Should Do.—We know what we should do to these journals, but it seems that we cannot understand the great harm that comes to the public and to ourselves by our inaction. In the United States there are 148,000 physicians. What can

the Nemaha County Medical Society do? Can it lead this vast host to the overthrow of this great fraud in America? Never doubt it. If we will say something to the point, and mean what we say; if we will do what we here pledge ourselves to do, in a short time there will not be one medical journal in the United States that will carry the advertisement of any patent or proprietary medicine.

When Darwin published his theory of evolution, on the fingers of one hand he could count his active and able supporters. He did not speak to a hundred thousand, to a mere million, but to the world. Today the world marches under his banner.

We shall say to the editors of the medical periodicals that our subscriptions will cease at the end of six months if there be on the pages the advertisement of any so-called medicine that has not received the indorsement of the Council on Pharmacy and Chemistry of the American Medical Association. In this the physicians of Kansas shall stand with us, and all other states shall stand with Kansas.

We shall not be entitled to great credit for this, nor will we deserve it; for the ground has been already prepared, and now the field is white unto harvest. The better class of editors and publicists, both lay and professional, have done the preliminary work; we sound assembly. The bugle call is "Forward"! and this Jericho of uncleanness, crime and murder is doomed.

Other reforms may be needed; but do this one thing first, for it is not given to humanity to see two steps ahead.

Every purchase of a nostrum is a mute appeal to us. Why do we sanction this evil? You would not leave a baby with poisonous sweets and sharp knives in its reach. We cannot escape the inexorable law: "I am my brother's keeper." Shall we longer defy that law, or, even more stupid, believe that the world is too busy or unconcerned to notice our delinquency? If the buyer of nostrums knew his dilemma, and was aware of our responsibility, he would demand of us that we justify his faith in the healing art.

Are we asleep?—What kind of armor plate does the physician wear who does not know that high officials of the state and nation, educators, and other leaders of the ranks of social reform are standing on one foot behind him and using the other vigorously? When we asked for legislation last winter did you feel the kick? In the last general election the physicians shaped Kansas history; but we failed to get protective legislation for the people. We were not trusted. It was believed by too many that we were

covertly seeking our own advantage. We were not, but the result was the same; instead of a beneficent law we got the laugh of sectarians, quacks, and fakirs. Why were we flouted? Because the petition we presented was soiled by our own hands, which were not lifted against the patent medicine orgy. We essayed rather to pluck the mote out of a brother's eye.

What We Will Give and What Receive.—The promise "blessed is he that considereth the poor" is still ours. When we shall have cleared away the foulness that is about him and ourselves, made a clean place for all to stand in, we shall be able to serve him with protective laws. He shall come to us and we shall give him no broken reed to lean upon. When this imperative reform shall have been accomplished he shall not go from us defrauded, as he now does from the patent medicine counter and the quack, his necessities unknown and only his pocketbook considered. He shall receive from a consistent profession light, guidance and relief.

The east is glowing with the dawn of this new regime. It shall be as spirited music to the weary marching column; as a tender sweet melody to the feet of dancing children; and it shall be said of the good physician:

A man shall be as an
hiding place from the wind, and
a covert from the tempest;
as rivers of water in a dry place;
as the shadow of a great rock
in a weary land.
And the voice of weeping shall be
no more heard, nor the voice of crying.
There shall be no more thence
an infant of days,
nor an old man that has not
filled his days.

(Isaiah.)

We Must Be Worthy.—Be assured, however, that science, training, skill, professional efficiency, refuse to be pushed beyond their inseparable, natural concomitant of moral and spiritual culture. The truth of this is exemplified in the lives of eminent physicians and surgeons throughout the land.

As this reform, now well begun, advances, it will draw to it other moral forces till its power for good will be unlimited. It will react on other social reforms till their united influence shall be irresistible. Prisons, schools and churches; public, cor-

porate and private business, and family life, shall welcome its broadening, healing influence.

When We Shall Enter the Promised Land.—This reform is preliminary to the medical profession's assuming its rightful place and duty as a state power. At its beckon peace shall hover, at its bidding war must cease. It must be the work both of individuals and of societies. An efficient army is composed of fighting units. "The protest of an individual has great weight with an honest editor and publisher."

All classes of people have their appropriate duties; to relegate patent medicine to history is our duty. The care of the body rests upon us. Millions are being poisoned daily while we remain idle in camp; they are exploited to minister to the greed of a sanguinary few. The relation of the manufacturer to the buyer of patent medicine is as unnatural as it is one-sidedly sinful. Contrast the isolated state of the buyer with the blessedness that came at last to Silas Marner, to whom was vouchsafed

"The remedial influence of pure, natural, human relations."

The body is the temple of the divine image. Through its avenues we touch the spirit.

"And he is a good physician who can heal the soul."

**Resolutions Adopted by the Nemaha County Medical Society.
October 30, 1913.**

WHEREAS, The manufacture and sale of patent medicines, so called, is a heavy burden laid upon the millions of ailing, innocent people by a class of mercenary criminals;

THEREFORE, By the Nemaha County Medical Society, be it

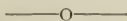
RESOLVED: First, that it is the imperative duty of all ethical physicians, individually and collectively, to protest to editors and publishers of medical periodicals against publishing patent medicine advertisements, as being accessory to the criminal traffic.

That we urge all physicians after a given time to discontinue receiving and reading such medical journals.

RESOLVED: Second, that we appeal to all physicians to discourage the manufacture and prescribing of the many multi-mixtures—"shot-gun prescriptions"—urgently presented to us even by our most trusted manufacturers.

RESOLVED: Third, that we submit these matters to the physicians of Kansas for further and wider consideration and

approval. That we request the secretary to send the proceedings of this meeting to the editor of the Journal of the Kansas Medical Society, and a copy of these resolutions to every newspaper published in Nemaha County; requesting each physician in the county to send to the secretary either his acceptance of the duty above outlined or his repudiation of it; to the end that we may estimate the strength of this movement among us.



EFFECTS OF EXPLOSION OF DYNAMITE CAPS ON THE TYMPANUM AND EXTERNAL EAR.

DR. R. S. MAGEE, Topeka, Kan.

Read before the Northeast Kansas Medical Society, Oct. 30, 1913.

On April 23rd, 1913, seven employees of the A. T. & S. F. R. R. at Cushing, Oklahoma, had gathered around a box of dynamite caps, looking at them, examining them curiously—not at work but with a curiosity to see how the caps were constructed. A fuse in some mysterious manner and without warning, suddenly ignited, an explosion occurred and in an instant the whole box of caps exploded. When the roll was called and an inventory was taken, two of the men were missing. Some thirty feet away the almost unrecognizable remains were discovered, which proved to be the missing two. The other five were able to get up and shake themselves together, and ever since have been trying to tell how it happened. The faces of two of them were badly burned, also their hands. One, the legs were burned and the skin broken in a number of places. One of them was in a box car nearby and says he was tumbled over into the corner of the car. Later, two of them developed perforations of both ear-drums. The other two, the skin was burned in the external auditory canals and some desquamation took place. The perforations probably did not occur until four or five days afterwards, following the desquamation which extended the whole length of the canals and over the surface of the tympanum. Infection with suppuration intervened in a short time on the denuded surfaces and the perforation ensued. In two of them—one ear in each—the perforation closed—the other ear in each—the perforation remained and will likely continue to do so. The hearing in all of them was practically undisturbed. None of them claimed impairment in hearing, strange to say, complaining only of a roaring noise which gradually disappeared in a short time. The suppuration along the canals

and through the perforations gradually ceased and in time the epidermal surface lining the canals and meatus healed. There are a number of interesting features in these cases to which I wish to call your attention:

1. The meatus and external auditory canal in two of them was burned the entire length, including the tympanum—in both ears. Would not be difficult to understand if only one ear in each subject.

2. With such terrific force as was there present, why more permanent damage was not done.

3. No perceptible impairment to the hearing, at least but slight, shakes the foundation of the old theory that deafness may be caused by standing near a gun or cannon when fired.

4. Out of the five only one received an eye injury, and that a trivial burn of the cornea, causing but little annoyance.

5. No impairment of the hearing in three of the cases whatsoever, and only slight in the other two with the perforation, and that in the ears in which the perforation was persistent—only slight—able to hear the whisper quite well—not willing to admit themselves that there existed even a perceptible impairment.

I want to present the picture of one of the men, showing the destruction of his overalls, completely riddling them into shreds as if they had been torn in strips ready for carpet rags. This man is one of the two whose tympanums were both perforated and is the only one whose legs were injured. Three of the others were sitting on the ground around the box, while this man was standing overlooking the others, watching what they were doing. This explains in part, at least, some of his injuries. At no time in any of them did the drum-heads show a pushing in or a pushing out, as might be expected from such violence. Reduction or an increase of atmospheric pressure from such an explosion is very likely to cause displacement of drum-heads with injury to the stapes, and in turn labyrinth producing injury to the internal ear, with permanent deafness. These caps are $1\frac{1}{4}$ to $1\frac{1}{2}$ inches in length and $\frac{3}{8}$ -inch in diameter, made to fit into a stick of dynamite; in the other end a fuse is inserted. A spark of fire ignites the cap, the force of the explosion is transmitted to the stick of dynamite setting it off. The force of the explosion is variously estimated from 500 to 1,000 lbs. per cap.

In closing I wish to say that a drum-head with a hole in it

is not a safe ear, being constantly open to infection, and is very apt to suppurate at any time and the infection to extend to deeper structures with still further loss of hearing.

RELATION OF THE PHYSICIAN AND THE EDITOR.

J. L. NAPIER, Newton, Kan., Editor Daily Kansan.

Read before the Harvey County Medical Society, Oct. 6, 1913.

The relation of the editor or the newspaper to the medical profession is, or should be, one of strictest confidence. By that I do not mean that the physician is obligated by professional relations, or compelled in his fidelity to professional ethics to rush to the editor with the details of his individual practice, or that he should be more interested in the newspaper, generally speaking, than other people should be interested. Rather, the newspaper should be of such character and reputation among its readers, and be so conducted that physicians will feel warranted in giving such facts regarding their practice as may properly concern the public, and suitable for reproduction in the public press. The editor who fails to exercise the utmost respect toward such a display of confidence, is as unworthy as the physician who fails to obey the quarantine regulations, or willfully falsely reports his diagnosis or other real facts which might concern the public.

To my mind the eradication of disease, the healing of the sick and the saving of human life, holds first place in importance among the profession. To rational and normal humanity the true advancement and betterment of mankind is paramount in the activities of each succeeding setting of the stage in the drama of life. It is a well established fact that strong and vigorous bodies, free from the ravages of disease and sickness, are essential to the end in view. This fact accounts for the research in laboratories, exhaustive experiments, great medical and surgical colleges, hospitals, training schools, etc. The average editor, accustomed by the force of his calling to search for the real facts, readily appreciates the great work in this regard which the medical profession has done and is doing for mankind.

As there are yellow journals, police gazettes and unscrupulous newspapers, so there are quack doctors, unskilled and doubtful healers of various sorts, and lecherous, unscrupulous self-styled specialists. No doubt every profession has its hinder-

ing and grafting parasites. I think physicians and newspapers particularly should take a nerve tonic and declare war on their respective barnacles. Our state editorial association a few years ago expelled a member who was proven guilty of a dishonorable act, and he was a man who was then prominent in public affairs, and has since held a prominent state office. The medical profession owes it to its members and to society generally to protect itself from impostors, so far as it is in its power to do so. In connection with this phase of the subject in hand, here is something I desire to mention in an impersonal way, yet with fear and trembling, lest it be misunderstood, as having come under my observation in the publication of a newspaper. It is generally understood to be a violation of professional ethics for reputable physicians to advertise, other than by the use of brief, dignified cards. Personally I honor the profession in that attitude. But people read advertisements, and they are influenced by them. Were it not so, impostors upon the medical profession would not continue to thrive. We all know their claims of bringing relief to a suffering world to be an iridescent dream, while the benefits and stability of their treatment is unabiding. Were the unsuspecting not influenced by advertising, the federal grand jury at Wichita a few days ago would not have found evidence on which to indict ten so-called specialists. The fact that he does advertise is not conclusive evidence to the mind of the unsophisticated, that the impostor is such. The paper I represent long ago established a rule to accept no advertisement at any price from so-called doctors whom we know to be of doubtful reputation. Less than three weeks ago we refused a very tempting proposition to advertise the practice of one of the men just indicted at Wichita for fraudulent use of the mails. I take it that one of the essential elements actuating the practice of a chosen profession is the livelihood derived therefrom, and hence the sacrifice to self-respecting newspapers in cases such as just mentioned is obvious. Now, it has occurred to me that many people who are susceptible to the influence of the glaring claims of quacks and nostrums, might be induced to refrain from following after false promises of relief from real or fancied disorders, were a genteel and dignified representation of our legitimate physicians found in the papers the people read. I hasten to apologize, and assure that this observation comes with no prompting of mercenary motive, but is merely offered as being in line with a frank discussion of the

subject in hand. Pursuing this phase of the mutuality of professions further, perhaps it should be suggested that as physicians are often called to attend upon cases which are undesirable from the very character of the disorder or the circumstances, so newspapers are often required to accept advertising they had rather had not been ordered. I refer to many of the proprietary preparations, some of which are no doubt valuable, but which are rendered suspicious by the nature of the advertising.

Perhaps the newspaper oftentimes over-estimates its importance in a community, or among its readers. Sometimes a paper fails to bring forth results desired regarding questions of public concern, or matters of reform even with its most ardent support. Such experiences are very likely to keep the editor close to earth, so to speak, and make him realize that he requires the support of the community in order to accomplish results even in the most obviously needed reforms. Many of these reforms pertain particularly to the public health, and here again do the physicians and papers find their relations running in mutual lines. While the news columns are expected to give the simple facts regarding current happenings, the editorial page is expected to reflect the policy of the people behind the paper. The proper kind of policy, assiduously enforced, means a fearless attitude on the part of the paper on the side of questions bearing on the public health, which the physicians of the community agree is the right side. As there is no question of graver concern to any community than the conserving of the public health, the duty of the physicians in putting the proper words in the newspaper, the mouthpiece for the people, is the most important civic function in community welfare. County officials may tell us all about bridges, roads, taxes, etc. City officials may tell us about the operation of the water works, paving enterprises and city buildings. We may get our facts regarding the administration of law from the judges and lawyers. The school officials may keep us posted on the progress of the children with their studies. The banks may be expected to speak to the people through the paper about finances, and so on through the long and varied list of human activities. But the most vital question rests with the physicians. The newspaper remains helpless in fulfilling its functions as they relate to the two great and important events in life—the alpha and omega of mankind—the births and deaths, if it has not established a proper relation with the physician.

The administration of comfort and tranquility to the transitory soul is a function of the ministry, but the noble task of keeping body and soul together unimpaired, and in His likeness, falls upon the physician. And it is a sacred task. The doctor is, or should be, the family friend, counselor and guide in temporal well-being. In my business experience as an editor I have met many, and few have I found wanting in the virtues demanded of the profession, and I believe I voice the sentiment of newspapers generally when I say that the editor who honors his profession and seeks at all times to preserve its dignity, considers the physician one of his strongest allies and friends, always courteous, genteel and whole-hearted, kind, companionable and honorable, unselfish, public-spirited, and withal dependable in all personal or community crises.

Nasal Catarrh.—The treatment Wilson (London Practitioner, October) has found most useful in cutting short an attack of acute coryza is the following: (1) A single pill of morphin gr. 1-6 made up with a little capsicum and ol. menth. pip. A small dose of nitroglycerin also is advantageous. (2) In two hours 10 grains of aspirin. (3) A hot bath. The following morning, a purgative dose of magnesium sulphate is given to clear away the intestinal contents held back by the morphin. Neither a nasal douche nor a spray should be employed, but an irritant antiseptic ointment containing menthol and salicylic acid, will best fulfill the purpose. A small portion of such an ointment is inserted well up into each nostril, where, if sniffed back, it gives rise to considerable smarting and secretion; it should be applied frequently despite the pain. It will be succeeded by a period of relief, and then the nose can be sprayed repeatedly with a sedative preparation. Despite the pain caused by the menthol-salicylic preparation, no cocain should be employed at all, as it paralyzes the ciliated epithelium and opens the way for fresh infection.

Collodion in Boils.—Furuncles are now being treated by painting a ring of collodion round the seat of the lesion. Repeated several times daily this has been found to exert a gentle and increasing pressure on the boil, which results in its eventually bursting, the core being expressed at the same time. The use of sodium citrate has also been advocated, a one per cent solution in normal saline applied on a gauze dressing having been found to set up a flow of lymph and maintain the fluidity of the serum.—Exchange.

THE JOURNAL

OF THE

Kansas Medical Society.

JAMES W. MAY,**EDITOR.**

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, D. R. STONER, J. A. DILLON, W. F. FEE.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1903, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 400-1-2 Portsmouth Bldg., Kansas City, Kas.

LIST OF OFFICERS. President. M. F. Jarrett, Fort Scott; 1st Vice-President, C. C. Nesselrode, Kansas City; 2nd Vice-President, J. F. Gsell, Wichita; 3rd Vice-President, G. A. Blasdel, Garnett; Treasurer, L. H. Munn, Topeka; Secretary, Chas. S. Huffman, Columbus

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B. Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, W. F. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, D. R. Stoner, Quinter; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

A Merry Christmas and Happy New Year to all.

May your troubles and disappointments be so few that the sunlight of your blessings will forever dissipate them.

—o—

That the efficiency of preventive medicine is exhibiting itself, your attention is called to the following report from New York City:

Lowest City Death-Rate.—The death-rate for this city for the week ending October 18, was the lowest ever recorded in the history of the health department. It was 11.20 per 1,000 population. The number of deaths for the week was 1,153, as against 1,243 for the corresponding week of 1912. One of the noticeable features of the report was the drop in infant mortality.

It seems to speak for itself!

—o—

Money Is Safe to Handle.—Currency bills, both washed and unwashed, are singularly free from germs, according to recent government tests. This condition is attributed to the fact that the ink used in printing the bills is an almost perfect germicide.

The above statement appeared in print and is certainly most

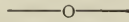
welcome news to us, as for years we have been afraid to handle bills owing to our former teaching, hence we have remained poor. Watch us from now on. It may become popular to employ printer's ink instead of iodine in abdominal operations.

The subject of medical examination and registration of physicians is one that should command attention. In the first place, without reciprocity among the different states of the Union a physician who, wanting to change his location, would have to submit to another examination. If he desired to make the change later in life, even though he was eminently qualified to practice medicine, the examination would require considerable time in reviewing subjects, some of which not having gone over since his school days, would make it a great hardship. It seems that a method even excelling national reciprocity would be the establishment of a National Board of Medical Examination and Registration, with a subsidiary board in every state in the Union. The examination questions could be issued by the national board and every applicant would then have to pass the same examination. This examination once passed would entitle the successful ones to practice in every state in the Union. To begin with, the national board would have to accept all legally registered physicians of the different states and require examination from all future candidates to practice medicine. It would certainly be an effective means of standardization of the requirements to practice medicine.

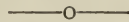
The annual meeting of the Clinical Congress of Surgeons was held in Chicago May 10-15, inclusive. The meeting was a decided success. The attendance, however, far exceeded expectation (between 4,000 and 5,000 registered), and as a result the clinics were packed far beyond comfort and benefit. It was thought that an abundance of space had been arranged for, but it proved entirely inadequate. The clinics for those who could get near the field of operation were held by men high in the profession, many of international reputation demonstrating new and brilliant operations. The congress will be held next year at London.

We cannot be reminded too often of the importance of early diagnosis of cancer of the breast and cervix. According to John B. Deaver, M.D., of Philadelphia, 80,000 women lose their lives every year from cancer. In his paper in the November issue

of the West Virginia Medical Journal, he urges the education of the laity to the end that co-operation with the profession will discover the disease at a time when operation will cure, and invokes public opinion "to shame the laggards and procrastinators, both in and out of the profession, that will attack the reputation of a man whose mal-advice permits a cancer capable of diagnosis or suspicion to reach the incurable stage." Just as strenuous in his arguments is J. Edward Burns, A.B., M.D., of Wheeling, W. Va., in the same issue of the above journal, on the subject of malignant tumors, particularly of the uterus. We are too prone to put too much dependence upon pain as an early symptom of cancer, when it is a fact that pain is a very late sequence. "Leucorrhea is, as a rule, the earliest symptom of the disease, and although quite commonly present in women at the cancer age, any increase in its amount, and particularly the slightest admixture with blood, should be looked upon as very grave." In our anxiety to educate the people on the subject of tuberculosis, which has done so much good, we must not overlook the vast importance of thorough instruction in the matter of cancer. Eugenics is interesting our preventive proclivities. Let us not forget cancer!



One Reason.—Many of us indulge in hasty penmanship, especially in such important matters as the writing of prescriptions, thereby giving the profession a reputation for carelessness in this respect which, on the whole, is undeserved. The habit of hurrying at everything we do is the only excuse for illegible writing, and it is just possible that when one considers one's time too valuable to permit the doing of good work the valuation placed on that time is too high. Properly writing a prescription so that it will be correctly filled, is as essential a part of a physician's work as is the making of a diagnosis. If there is any vocation in which there are no trifles, in which there is no excuse for negligence at any point, it is the practice of medicine, and fortunately or unfortunately our patients seem to be learning this fact.—H. B. C.



The general principle involved in having boards of examination and registration for physicians, pharmacists, dentists, nurses, and veterinarians, all will concede is right, and if we are to criticize, it must be to call attention to the method of conducting these examinations to test the qualifications of applicants.

In the first place, each member of the board should be given a subject to examine upon with which he is most familiar, and in the second place "catch" questions should never be asked for they neither reflect any credit for extra-intelligence on the part of the examiner, nor prove the fitness or unfitness of the applicant.

An examination which really decides the fitness of an applicant for the practice of any profession must of necessity be of a practical character, and so far as medicine is concerned, we hope the time is not far distant when every applicant for a license to practice medicine will be compelled to pass a clinical examination in addition to the other requirements.—H. B. C.

We hope the physicians of Kansas will not lose sight of the fact that no drug is advertised in the pages of their state journal that has not been approved by the Council on Pharmacy and Chemistry of the A. M. A.

No doubt there are many remedies used by the profession of the state which have not thus been approved, but it should not be so. The council has no exactions that cannot be met by any honest firm. The council is the only body which stands as a protector of the medical profession against misrepresentation and fraud on the part of unscrupulous manufacturing chemists. It is, as it were, like a clearing house, which sets the seal of approval on preparations that are offered to the medical profession.

If a doctor goes to a town where he is not known and asks for credit, he is promptly met with a request for recommendations. His own word is not accepted as evidence of his responsibility. If he wishes to borrow money from a bank, the bank officials may be morally certain that the obligation will be canceled according to promise, but before the money is handed over, your name must be appended to a note and perhaps, too, that of a friend to endorse it.

No one takes exception to this fair and business-like way of conducting business.

Likewise, we should demand that preparations which we are asked to use, shall have the endorsement of the council, and there is no good and sufficient reason why the manufacturers should offer the slightest objection to the requirement; in fact, the endorsement of the council should be sought rather than shunned.—H. B. C.

SOCIETY NOTES.

Stafford County Medical Society met at Stafford November 12th. Papers were read by Drs. C. S. Adams, L. E. Mock and J. C. Butler.

—o—

The Wyandotte County Medical Society will hold its annual banquet at the Grund Hotel, Kansas City, Kansas, January 13th. The council will hold its semi-annual meeting in the afternoon and in the evening they, with the other officers of the state society, will be guests of the society. Wyandotte County, due almost entirely to the efforts of the secretary, Dr. J. F. Hassig, has a membership of one hundred and eight, and is a medical society worthy of the name.

—o—

Newton, Kansas, November 6, 1913.

Editor Journal Kansas Medical Society.

Kansas City, Kansas.

Dear Sir:

The Harvey County Medical Society held its regular meeting at Newton with an attendance of twenty-one; Newton, Burrton, Halstead, Whitewater, Hutchinson and Topeka being represented. Four applications for membership were reported. The regular program was postponed for one month and Dr. E. H. Skinner of Kansas City gave a lecture on "Abdominal Diagnosis by the Roentgen Ray," illustrated by lantern. The meeting was preceded by an elaborate supper at Unruh's cafe. Our programs are interesting and attendance good.

FRANK L. ABBEY, Sec'y.

—o—

NEWS NOTES

Dr. Hugh Wilkinson of Kansas City, Kansas, has announced that hereafter he will confine his practice to surgery and consultations.

—o—

Dr. C. C. Nesselrode of Kansas City, Kansas, announces the birth of an eight-pound baby girl.

—o—

Dr. John G. Missildine was married to Miss Sara Taft October 15th. Both live at Parsons.

Dr. Andrew Pearson of Wakefield was seriously injured in an automobile accident October 25th.

Dr. George Nealley of Lansing is reported to be seriously ill as a result of a cerebral hemorrhage.

Dr. Mark L. Bishoff of Topeka has recently been appointed superintending physician of the Santa Fe Employees' Hospital at Fort Madison, Iowa.

The following physicians from Pittsburg attended the meeting of the Medical Association of the Southwest, which recently met in Kansas City, Mo.; Drs. Bogle, Graves, Stelle, Harper, Dickinson and Caffey.

Dr. J. J. Sippy of the State Board was "rounding up" the doctors in the Southeast during October. He says on the whole physicians are generally complying with the laws relative to vital statistics and tuberculosis reports, but occasionally he has to "remind" them.

The City Hospital of Pittsburg closed its doors on the first of October, Dr. Geo. W. Williams, president of the hospital, and for nearly thirty years chief surgeon on its staff, retiring from practice. This institution, for many years the only hospital in the county, has served the people of this community well.

Dr. W. L. Borst has moved from Topeka to Meriden, Kans.

Dr. J. B. Robinson has moved from Hiattville to Browning, Missouri.

Dr. E. J. Beckner, formerly of Grainfield, has moved to Hoxie where he will practice with his brother, Dr. C. D. Beckner.

Dr. J. J. Barclay of Grinnell suffered a complete loss of his office building and equipment recently by fire.

Dr. J. M. Eisenbise of Quinter has recovered from his recent operation for appendicitis and diverticulitis, followed by a siege of typhoid fever.

A Woman Physician—Is needed at once for the Presbyterian Hospital and Dispensary at Tsinanfu, North China. The requirements are thorough medical training and considerable experience in practice. The applicant should possess a sound constitution and good health, good sense, ability to work harmoniously with others, and the dominating purpose to make her life and work contribute directly to the Christian and religious aim of the mission. Adequate support, including salary, traveling expenses, living quarters, etc., is provided. Further information may be obtained of Mr. Wilbert B. Smith, Candidate Secretary Student Volunteer Movement for Foreign Missions, 600 Lexington Avenue, New York City.

Dr. James Welch of Tampa has sold his practice to Dr. C. E. Yates and has located at Junction City.

OBITUARY.

Nathan J. Saunders, M.D.—College of Physicians and Surgeons, Kansas City, Kansas, 1897, a Fellow of the American Medical Association; died at his home in Glen Elder, Kansas, October 25th; aged 52.

Dr. F. A. Hall, Hoxie, Kansas, died suddenly of apoplexy October 21, 1913, at his home; age 60 years. Dr. Hall was one of the pioneer physicians of Sheridan county and northwest Kansas, a member of the Tri-County and Kansas State Medical Societies and district surgeon of the Union Pacific Railroad.

George M. Howe (License, Kansas, 1909) of Wichita, Kansas, and later of Kansas City, Missouri; died in Oklahoma City, Oklahoma, September 26th, from heart disease; aged 42.

Charles McBurney, M.D.—Four weeks ago The Journal chronicled the death of Dr. Reginald Heber Fitz, who called attention to the pathology of appendicitis and thus opened the way to a clearer understanding of the disease and the possibility of its cure by surgical means. Today we note the death of Dr.

Charles McBurney, whose operative work in appendicitis brought him into great prominence during his years of active work, and whose recognition of a point of localized tenderness in appendicitis has made McBurney's point known the world over.

Charles McBurney was born in Roxbury, Mass., February 17th, 1845, the son of Charles and Rosine Horton McBurney. He received his academic training in Harvard, from which he received the degree of A. B. in 1866, and that of A. M. in 1869. His medical course was taken at the College of Physicians and Surgeons, Columbia University, New York City, from which he was graduated in 1870. His teaching work commenced in his alma mater in 1872 as assistant to and demonstrator of anatomy from 1872 to 1889. During a portion of this period, from 1878 to 1882, he was lecturer on anatomy of the nerves and surgery. In 1889 he was made professor of surgery; three years later professor of clinical surgery, and in 1907 he became emeritus professor of surgery.

During his forty years of practice in New York City he was a member of the visiting or consulting staff of many hospitals. He was a Fellow of the American Medical Association, an honorary Fellow of the Royal College of Surgeons, Edinburgh, a member of the New York Academy of Medicine, the Surgical Society of Paris, the Roman Medical Society, the Medical and Surgical Society of Constantinople, and many other learned bodies. His first contribution to the medical literature of appendicitis appeared in 1889 when he published an essay on "Experience With Operative Interference in Cases of Disease of the Vermiform Appendix."

For several years Dr. McBurney had been retired from practice and resided in Stockbridge, Mass. From his home in this place he was summoned to Buffalo in 1901 as a consultant when President McKinley was shot.

He died suddenly from heart disease at the home of his sister in Brookline, Mass., November 7th; aged 68.

In addition to his work in appendicitis which brought to American surgery recognition from the entire world, Dr. McBurney was a pioneer in aseptic technic.

JOURNAL A. M. A.

—o—

RESOLUTIONS.

WHEREAS, Major J. L. Fryer of the Western Branch,

National Home for Disabled Volunteer Soldiers, and a member of the Leavenworth County Medical Society, has been requested by the Board of Managers to resign as surgeon of the Western Branch; be it

RESOLVED, That we hold Major Fryer in the highest esteem as a gentleman and a true physician of the highest professional qualifications, and a valued member of the Leavenworth County Medical Society; and

RESOLVED, That we bear witness to his efficiency in the management of the Soldiers' Home Hospital; and

RESOLVED, That we regard the charges by the Board of Managers against the administration of Major Fryer as unjust, shameful and outrageous, and wholly unfounded; and

RESOLVED, That we feel that the character and reputation of a truly worthy member of the medical profession of the nation has been blighted and disparaged; and

RESOLVED, That the Leavenworth County Medical Society enter the most vigorous protest against, and condemn, the action of the Board of Managers in their unwarranted action in asking for the resignation of Major Fryer; and be it further

RESOLVED, That a copy of these resolutions be submitted to the individual members of the Board of Managers, to the governor of the Western Branch, Home for Disabled Volunteer Soldiers, to the President of the United States, to the presiding officer of the United States Senate, to Senators Thompson and Bristow, the representatives in Congress from Kansas, to Governor Hodges of Kansas, to the Associated Press, to the American Medical Association, to the Kansas Medical Journal, to the Jackson County Medical Society of Kansas City, Mo., to the press of Leavenworth, and to Major Fryer and his family.

F. J. HAAS, M.D.,

(Attest)

Chairman,

J. L. EVERHARDY, M.D.,

September 18, 1913.

Secretary.

REVIEWS.

Two important and timely topics are presented in the November issue of the Providence Medical Journal, both original and embodying the actual experience and comprehensive clinical reports, besides the evident unbiased manner in which they are written.

The first is a paper entitled "A Preliminary Report on 120

Cases of Tuberculosis Treated With Friedmann's Vaccine," by Harry Lee Barnes, M.D., Supterintendent State Sanitarium, Wallum Lake, R. I. Sixty-nine of these cases were treated at the sanitarium by Dr. Friedmann himself, on April 9th, 1913. Dr. Barnes describes the technique, which is very simple; the reactions, which are variable; the character of the indurations upon which Dr. Friedmann lays much stress; the abscesses following the injection; the pus or serum containing acid fast bacilli in abundance; the variance in leucocytic count, and the Arneth blood count. He then follows with concise case reports, comparing condition of patients before and after treatment as to early symptoms, cough, expectoration, tubercle bacilli in the sputum, loss of appetite, emaciation, insomnia, chest pain, constipation, fever, night sweats, haemoptysis, physical signs and complications. He concludes his article as follows:

"From the above table it appears that 40 per cent of the patients are not in as good condition today as when they received their first injection of vaccine. The number of cases discharged from this institution as unimproved has so far never exceeded 23 per cent. The unfavorable result in many cases appears to be due to the increased activity of the pulmonary leisons as a part of and following reactions to the vaccine. In several cases the signs of increased activity have subsided or are subsiding, while in others, even after five months, there is as yet no sign of decreased activity. Whether these exacerbations will entirely subside and later be followed by unusual improvement cannot at this time be stated, but it does not seem likely, nor was such a claim made by Friedmann. These reactions have much clinical similarity to those which followed the therapeutic use of tuberculin in excessive doses soon after its discovery.

SUMMARY.

1. The vaccine bacilli were not always acid fast.
2. One injection of vaccine was harmless to guinea pigs and turtles.
3. Fourteen per cent of patients had fever reactions above 100 F.
4. Inoculation indurations after first injection were present in 70 per cent.
5. The average duration of the indurations was 41 days.
6. Abscesses occurred in 23 per cent.
7. The average duration of discharge from abscesses was 23 days.
8. The cough and expectoration showed no striking improvement.
9. Bacilli persisted in the sputum in 85 per cent of positive cases.
10. The usual appetite continued, except in reaction patients, in whom it was worse.
11. Vaccine patients lost more weight than others.
12. Twenty per cent had improvement in chest pain, the remainder being unchanged or worse.
13. Patients had more fever and night sweats after the vaccine than before.

14. Blood spitting was at least as frequent in vaccine-treated as in other patients.

15. There was no unusual tendency toward disappearance of physical signs, which were increased in many patients who were improving before.

16. Forty per cent of the 85 patients whose present condition is known at an average period of four months after the first injection are worse.

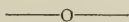
CONCLUSIONS.

1. This report offers no evidence as to whether or not the vaccine can prevent tuberculosis in those who are free from it, as no healthy persons were inoculated.

2. It offers no evidence as to the liability of the vaccine to induce local or general tuberculosis, as this can be determined only by autopsy or special bacteriological work.

3. The one patient with joint tuberculosis showed striking improvement, which makes it desirable that similar patients who have received this vaccine should be observed and reported on by those who have had orthopaedic experience. The four other patients having active tuberculosis outside the lungs have not shown unusual improvement.

4. The 120 patients having pulmonary tuberculosis have shown none of the immediate and wonderful results reported by Friedmann and others before the Berlin Medical Society. On the contrary, about 17 per cent of the cases have shown an increased activity of the disease, which would not have been expected under ordinary sanatorium treatment. The permanent good or harm done these patients can only be measured with reasonable accuracy from one to three years after the administration of the vaccine."



The other paper, by James Hamilton, Jr., describes "The Prophylactic and Therapeutic Vaccine Therapy in Typhoid Fever." During three years as interne in the Rhode Island Hospital, he made careful comparison of typhoid cases treated with and without vaccine, which is best described by quoting his analysis:

"To eliminate chances of error in this matter and present figures rather than opinions, I have compiled some data from the typhoid records beginning in July, 1910, and ending in June, 1913. I have compiled this data as accurately as possible and, although I intended to go into some detail in many of the cases, I found the task of going through the three years' records a Herculean one; hence, I will omit all detail and keep strictly to the facts.

This data is compiled from the charts of 270 typhoid patients. Seventy-five of these patients I treated with vaccine.

The average age was twenty-two years.

There were 176 male patients, or 65.6 per cent.

There were 94 female patients, or 34.4 per cent.

It is interesting to note that the incidence of typhoid fever is almost twice as great among the males as among the females.

Duration of fever of patients not treated was 26 1-3 days.

Duration of fever of patients treated with vaccine was 17½ days.

Number of days in hospital of cases not treated with vaccine was 43 6-7 days.

Number of days in hospital of cases treated with vaccine was 31 3-5 days.

Number of deaths in hospital of cases not treated with vaccine, 32, or 16 per cent.

Number of deaths in hospital of cases treated was 9, or 12 per cent.

Five of the deaths among the treated cases were patients who were in late stages of the disease on entrance to the hospital. Two of the five were moribund on entrance and the other three were having hemorrhages.

Number of patients not treated but discharged cured was 160, or 82.05 per cent.

Number of patients treated but discharged cured was 66, or 88 per cent.

Number of patients not treated who had hemorrhages was 32, or 16.4 per cent.

Number of patients treated who had hemorrhages was 8, or 10.6 per cent.

Number of patients not treated who had perforations was 10, or 5.13 per cent.

Number of patients treated who had perforations was 1, or 1.3 per cent.

Number of patients not treated who had severe diarrhoea was 26, or 13.3 per cent.

Number of patients treated who had severe diarrhoea was 2, or 2.6 per cent.

Number of patients not treated who had delirium was 41, or 21 per cent.

Number of patients treated who had delirium was 8, or 10.6 per cent.

Number of patients not treated who had boils and abscesses was 20, or 10.25 per cent.

Number of patients treated who had boils and abscesses was 5, or 6.6 per cent.

Number of patients not treated who had marked distention was 7, or 3.5 per cent.

Number of patients treated who had marked distention was 0, or 0 per cent.

Duration of the fever before first treatment was 4 3-5 days.

Number of vaccine treatments was 309.

Average number of treatments was 4.

Smallest number of treatments was 1.

Largest number of treatments was 9.

I think these figures are rather convincing to any fair minded person. The figures rather surprised me, although I felt that as a whole the patients treated with vaccine did better than those untreated; still I did not think that compiled data would be so convincing. I am inclined to think that vaccine therapy in typhoid fever is of some therapeutic value. To be sure, there are cases where the treatment seems to be of no avail, but inasmuch as it seems to do no harm, I think it

is worthy of trial in every case. In all sincerity I feel that I can recommend its usage."

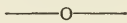
He is an ardent exponent of typhoid vaccine as a prophylactic measure, and believes that it should be compulsory for the nurses and attendants in all hospitals.

The conclusions arrived at by Dr. A. E. Benjamin, Minneapolis, Minn., in a paper read by him before the Southern Minnesota Medical Association at Owatonna, Minn., August 6th, 1913, and published in the November St. Paul Medical Journal, on the subject of "Gastroptosis and Coloptosis," is as follows:

1. Gastroptosis and coloptosis are often associated and interdependent.
2. Gastroptosis is extremely common the world over.
3. There are many men as well as women who are suffering continually or are disabled owing to the misconception of this disease on the part of the practitioner.
4. The disease is often unrecognized and incorrectly treated.
5. It is confounded with many others such as ulcer of the stomach, gall-stones and cancer, or treated as indigestion, and neurasthenia; many cases being operated upon for appendicitis, or an exploratory operation is performed for a possible ulcer at which time a gastro-enterostomy is sometimes done unnecessarily.
6. Gastroptosis as an antecedent factor in gastric ulcer or cancer, cannot be denied.
7. The majority of these cases do not come to the surgeon, but are treated by the general practitioner, internist or nerve specialist, the stomach complaint being considered an outgrowth of a nervous condition.
8. The recognition of gastrocoloptosis as the cause for constipation has often been overlooked.
9. The patients travel from one physician to another and try one remedy and then another as a rule without relief. They become discouraged, depressed and neurotic.
10. Gastrocoloptosis is followed by stasis, with multiplication of infectious micro-organisms. Increased tension results in additional absorption, with systemic intoxication, manifest by local, general and reflex symptoms in proportion to the degree of stasis.
11. The functional capacity and position of stomach and colon should be always inquired into and absolutely determined by the X-ray.
12. Physicians in general must familiarize themselves with the symptoms as herein mentioned, of the disease, so as to adopt early and prompt methods for relief of the innumerable cases suffering with the disease.
13. Proper poise, early development of general and local abdominal muscle tone, as prophylactic means of gastrocoloptosis must be recognized.
14. An operation should be advised in cases unrelieved by medical means, in which there is pyloric or colonic obstruction with stasis and systemic intoxication.

15. All cases operated upon should be followed up and the subsequent treatment carefully managed.

16. When physicians in general become familiar with the symptoms of this disease and its far-reaching effect upon the human system by the consequent stasis and toxemia, and familiarize themselves with the best line of treatment to adopt in a given case, and have these patients undergo the necessary treatment or surgical procedure early, they will relieve quite a portion of their would-be chronic invalids and convert them into grateful, useful and happy citizens.



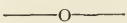
In a most admirably presented paper on Fractures of the Skull by Louis M. Warfield in the Wisconsin Medical Journal for November, 1913, the author lays great stress upon the diagnostic importance of the two easily demonstrable phenomenae in the early and obscure pathology of the condition. By the use of the ophthalmoscope a "choked disk" in its incipency discloses an edema of the optic disk commencing with slight haziness of the nasal margin through various degrees of swelling to complete optic atrophy. This is an early symptom of compression caused by injury to the cranial contents.

The author insists that it is not sufficient to only examine the disk once, but that it should be repeated daily or oftener, thereby giving a correct clue as to the time for operation in order to relieve the compression. "One must actually measure the blood pressure." Therefore the sphygmomanometer is a necessity to judge the tension of the circulation. High blood pressure urges decompression at the earliest possible moment.

Barring other conclusive symptoms, these two will enlighten an early diagnosis.

MISCELLANEOUS.

Red Cross Symbol.—Physicians who use the symbol of the Red Cross on their automobiles, and makers of medicines who use this symbol have been informed by the head of the Red Cross Society in Cincinnati that by the use of the symbol they are violating a federal law, and are thereby subject to a fine of not less than \$1 nor more than \$500, or a term of imprisonment not to exceed one year, or both.—From The Military Surgeon in McLean County Bulletin.



Laugh on Doctor.—A Chicago physician recently motored to Columbus, where he spent several days with friends on the east side. While downtown one day, he left his touring car standing in front of the Chittenden Hotel, and when he came

out he saw the negro doorman standing back of the machine laughing.

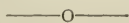
"What's the giggle?" queried the doctor.

"Nothing, boss," answered the genial doorman. "But you're a doctor, aren't you?"

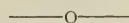
"Yes."

"I thought so when I saw the red cross on the front of your machine, but if I owned that car I'd take that sign off the back."

The doctor went around to the rear and looked at the license tag. It read, "35,000 Ill."—Columbus, O., Dispatch.



Another triumph of American skill in hygiene and sanitation in tropical countries is chronicled in the recently published year book of the Philippine Bureau of Health. Director of Health Victor G. Heiser, who is also past assistant surgeon of the Public Health and Marine Hospital Service, sums up the situation in the islands as follows: "On account of the state of the public health at the close of the year, and the satisfactory conditions under which the new year is begun, it is believed to be safe to state that we are on the threshold of the time when the expectancy of life in the Philippines will compare favorably with that in other parts of the world, and that it will be safe for commercial enterprise to make its calculations for the future without fear that disastrous epidemics with their attendant quarantine and other restrictions must be reckoned with."



The Medicine of Our Forefathers.—What our forefathers accomplished in medicine was chosen as the subject of a paper by Dr. J. J. Walsh, of New York (Journal A. M. A., November 15). He finds in the history of medicine of the earlier days that some form of anesthetic was used as early as the seventeenth century, that the healing of wounds by first intention was aimed at, and operations were done on the skull for tumor and abscess, and in fact that practically all our surgical discoveries of recent times have been anticipated in the distant past. Even one of our latest triumphs, the suppression of yellow fever, seems to have been anticipated in many of its ideas in an old pamphlet by a Dr. Potter, published in the beginning of the last century. As regards medical education the requirements of the first medical schools in this country largely anticipated modern demands. Modern views as regards consumption, the use of cold water in fever, and other matters could likewise be quoted from older writings in like manner. He says our phil-

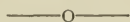
osophy, our literature, our poetry, our art, are nearly all old, and what is best is of the olden time, and asks why should not this be true with regard to medicine, at least enough to make us realize its glorious past history.

Arrested Development.—"It will be comforting to those who have been concerned about the spread of Christian Science to learn that the last year has shown no increase whatever. In the whole of the United States there are only 83,500 people who confess that they belong to that body, and there are only a trifle over 5,000 in the whole of Canada. These are the official statistics just published, and it is a source of gratitude to know that this modern delusion of inconsistencies, contradictions and absurdities has reached its climax—henceforth it will quietly disappear. Thank God."—Watchword and Truth.

The Elastic Area in the Isthmus of the Uterus as a Positive and Early Sign of Uterine Pregnancy (Louis J. Ladinski, *American Journal of Obstetrics*, August, 1913).—Ladinski emphasizes a diagnostic sign for early pregnancy that he had previously published, owing to the constancy with which this sign appears in early gravidity. It consists of a circular area situated in the median line of the anterior surface of the body, of the uterus, just above the junction of the body and cervix, that is to say, at the isthmus of the uterus, which varies in size according to the duration of pregnancy, and offers to the palpating finger the distinct sensation of elastic fluctuation. It can frequently be made out as early as the fifth week, when the area is only the size of a finger-tip; but it can always be felt in the sixth week, when it is somewhat larger. As pregnancy advances this area increases in size in a crescentic manner and extends upward toward the fundus until the third month of pregnancy, when nearly the entire anterior body of the uterus presents a fluctuating, cystic feel to the examining finger.

Most Pupils Were Defective.—Port Huron, Mich.—Startling revelations in connection with the sanitary condition of Port Huron schools were made when it was announced that of a total of 1,652 pupils in the local grades, representing one-half of the school population, 1,081 were medically defective and only 571 in normal health. The investigation was conducted by a number of Port Huron physicians, who gave their

services free, and was held under the auspices of the Parents'-Teachers' Association.—From the Detroit Free Press.



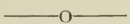
A Pean of Praise.—Editorial sanction of ragtime in the hospital comes from the Springfield (Mo.) Republican, because the editor does not want to be reminded of his editorial sins or the possibility that he may be on the way to receive his punishment. He sings as follows:

"We are not accustomed to look for anything good to come out of Wichita. That is why we are so surprised to hear a particularly sensible and timely note sounded there with respect to a matter which has long needed to be treated in just that way. Why it has not been elsewhere, and long ago, we are at a loss to know.

"Wichita hospitals have adopted a rule that only bright and happy songs shall be sung by persons visiting those institutions to cheer the patients with music. There must be no allusions to death, nor to sorrow or its concomitants. Singers whose repertoire consists only of selections of the kind tabooed will be asked to save their vocal efforts for other places than hospitals.

"A sensible idea, assuredly. Who, flat on his back in a hospital, with possible death leaning over the pillow, wants the task of feeling cheered up over songs relating to 'The Sweet Bye and Bye,' 'Over There' or 'Waiting and Watching for Me'? Not we, let it be set down. We are not at all partial to the 'popular songs of the day,' but when we are sick it's the kind of singing we call for. None of the resigned-to-death kind for us while there's a fighting chance to recover.

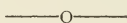
"The Wichita hospital idea is a fine one. People all over the country will want to get sent there when they are sick—or perhaps the same rule can be adopted in other like institutions."—Exchange.



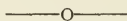
Scale of Fees Under the New Insurance Law in England.—

Visit to patient at patient's house or attendance on patients at doctor's consulting rooms.....	62 cents
Special visit, in response to messages left between 10 a. m. and 8 p. m.	87 cents
Night visit, in response to calls received between 8 p. m. and 10 a. m.	\$1.25
Surgical operations requiring general anesthetic or case of abortion or miscarriage.....	\$5.10

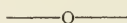
Administration of general anesthetic.....	\$5.10
Setting of Fractures—	
Femur.	\$5.10
All other fractures.....	\$2.50
Subsequent attendance at visit rates.	
Reduction of Dislocations—	
Hip.	\$5.10
Others.	\$2.50
Subsequent attendance at visit rates.	
Midwifery Fees. Minimum fee.....	\$5.00
Hypodermic injections or vaccinations.....	12 cents



For Sale.—Articulated skeleton; French; high grade. Address H. W. R., care Journal.



The American Journal of Surgery will present in January an issue of their journal, devoted exclusively to fractures and their treatment. Following are the contributors: F. J. Cotton, Boston; Lewis A. Stimson, Fred Albee, John C. A. Gerster, W. H. Luckett and Chas. Elsberg of New York; James K. Young, Philadelphia; W. L. Estes, South Bethlehem, Pa.; E. S. Van Duyn, Syracuse, N. Y., and E. P. Magruder, Washington, D. C.



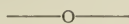
WHAT OSLER DID SAY.



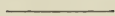
Much has been written in the medical and lay press of Dr. Osler's views on vaccination, of the much considerable has been made to carry the idea that he himself doubted its efficacy. We have never been able to seriously entertain such a possibility, but not having the address from which the idea had its origin we were unable to determine whether or not the pros or cons were right. One of our exchanges has lately published Dr. Osler's statement of his views on the subject, and the statement is so decisive that it is entirely proper to pass it on. He says:

"I do not see how anyone who has gone through epidemics as I have, or who is familiar with the history of the subject, and who has any capacity left for clear judgment, can doubt its value. Some months ago I was twitted by the editor of the Journal of the Anti-Vaccination League for a 'curious

silence' on this subject. I would like to issue a Mount Carmel-like challenge to any ten unvaccinated priests of Baal. I will go into the next severe epidemic with ten selected vaccinated persons and ten selected unvaccinated persons—I should prefer to choose the latter—three members of parliament, three anti-vaccination doctors, if they could be found, and four anti-vaccination propagandists. And I make this promise—neither to jeer nor jibe when they catch the disease, but to look after them as brothers, and for the four or five who are certain to die I will try to arrange the funerals with all the pomp and ceremony of an anti-vaccination demonstration.”—Medical Fortnightly.



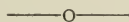
CLINICAL NOTES



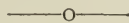
SURGICAL SUGGESTIONS FROM AMERICAN MEDICAL ASSOCIATION.



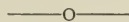
Melted vaseline is an important adjunct in the transfusion paraphernalia. Frequently applied at the site of junction, it minimizes any tendency to clot formation.



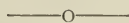
As a quick method of cauterizing the appendix stump, amputate the organ with knife or scissors dipped in pure phenol.



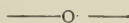
In case of intractable “dyspepsia” persistent tenderness in the right iliac region is suggestive of chronic appendicitis as the cause.



In edema of the lungs of cardiac origin a small dose of morphine often does more good than all the stimulants. It may be the only treatment needed.



Glass and tube drains should never be allowed to rest against a large bloodvessel (e. g., the epigastric, the internal iliac). They may cause fatal erosion.



If vomiting after a laparotomy persist in spite of treatment, especially in cachectic individuals, inspect the wound. Occasionally the cause is prolapse of abdominal contents through the opened incision.

—○—

Subacromial bursitis resulting from indirect violence (the usual cause), is often, if not always, associated with and due to injury to the supraspinatus tendon. A calcareous deposit often forms in the tendon which in the X-ray plate must be distinguished from fracture of the greater tuberosity.

—○—

A not uncommon cause of persistent pain in the knee is bursitis sartorius, semimembranosus beneath the inner hamstring tendon insertions.

—○—

X-ray plates, properly interpreted, are of great service in the diagnosis of mastoiditis, acute and chronic. Stereoscopy and comparison of the pictures of the two sides enhance the value of the radiographic examination.

—○—

The occasional occurrence of subperiosteal fracture of the patella should be borne in mind as a possible explanation of continued disability after trauma or muscle violence. It is only one of the conditions that radiography may elucidate which other means of examination of the knee fail to reveal.

—○—

What Is a Minimum Dose of Calomel?—We notice that some manufacturers put up calomel in as small as 1/100 grain tablets. The individual who conceived the idea of making tablets containing this infinitesimal amount of calomel evidently is lacking in clinical knowledge of the use of this important drug. Even infants tolerate relatively large doses of the mild chloride of mercury, owing to their copious and mobile secretions. Giving calomel in less than one-tenth or one-fourth grain doses to infants or adults is firing into empty space.—Medical Summary.

—○—

Edema of Extremities.—Treatment.—Where edema of legs resisted all measures, especially where incision not permitted, good results obtained from local use of hypertonic saline solutions—25 to 50 Gm. (3-4 to 1 1-2 ounces) of sodium chloride to 1 liter (quart) of distilled water. Soak gauze compresses lightly in this, wrap around legs, and cover with thick layer of absorbent cotton, held in place by bandages. Leave dressing on over night. Equally good results in edemas due to broken compensation, Bright's disease, etc.—Pathoult.

Neo-Salvarsan

AND THE

Apparatus for administering same, both by intravenous and intramuscular injection.

We also have a large and up-to-date stock of all Surgical Instruments, Leather Goods, Rubber Goods and Furniture; including Physician's Office and Hospital Equipment. Send for Catalogue.

**Especially Elastic Goods, Supporters,
Trusses and Hosiery.**

Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Flat Foot and Manner of Correction, Seth A. Hammel,	1
Appendicitis and Some of Its Obscurities for the Surgeon and General Practitioner, Dr. J. C. Shaw,	6
Psychotherapeutics, Dr. W. H. Young,	9
Physiology and Pathology of the Puerperium, Dr. E. A. Reeves,	13
Differentiation of Symptoms Located in the Epigastrium, E. E. Hubbard, M. D.	18
EDITORIAL,	28
EDITORIAL CLIPPINGS,	29
SOCIETY NOTES,	31
NEWS NOTES,	33
OBITUARY,	34
RESOLUTIONS,	35
REVIEWS,	36
MISCELLANEOUS,	39
CLINICAL NOTES,	41

1300 CASES OF RHEUMATISM

TREATED WITH

RHEUMATISM PHYLACOGEN.

MORE THAN

1100 RECOVERIES.

Full information concerning this
remarkable therapeutic agent sent
to physicians on request.

PARKE, DAVIS & CO.

DETROIT, MICH.

Neo-Salvarsan

AND THE

Apparatus for administering same, both by intravenous and intramuscular injection.

We also have a large and up-to-date stock of all Surgical Instruments, Leather Goods, Rubber Goods and Furniture; including Physician's Office and Hospital Equipment. Send for Catalogue.

Especially Elastic Goods, Supporters, Trusses and Hosiery.

Physician's Supply Company,

1005-07 WALNUT STREET, KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Tonsils and Adenoids, Dr. H. L. Scales.....	43
Artificial Infant Feeding, Dr. J. T. Scott.....	46
Syphilis, Dr. M. K. Lindsey.....	55
Treatment of Lobar Pneumonia, Dr. X. Olson.....	59
EDITORIAL.....	64
SOCIETY NOTES.....	82
NEWS NOTES.....	86
OBITUARY.....	87
REVIEWS.....	88
MISCELLANEOUS.....	90
CLINICAL NOTES.....	93

OVER

**4000 CASES
OF INFECTION**

HAVE BEEN
TREATED WITH

PHYLACOGENS.

RESULTS:

**90% OF
RECOVERIES.**

RHEUMATISM PHYLACOGEN.
GONORRHEA PHYLACOGEN.
ERYSIPELAS PHYLACOGEN.
PNEUMONIA PHYLACOGEN.
MIXED INFECTION PHYLACOGEN.

Let us send you complete literature.

PARKE, DAVIS & CO.

DETROIT, MICH.

Neo-Salvarsan

AND THE

Apparatus for administering same, both by intravenous and intramuscular injection.

We also have a large and up-to-date stock of all Surgical Instruments, Leather Goods, Rubber Goods and Furniture; including Physician's Office and Hospital Equipment. Send for Catalogue.

**Especially Elastic Goods, Supporters,
Trusses and Hosiery.**



Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
The Wassermann Reaction in Relation to the Diagnosis and Treatment of Syphilis, Lindsay S. Milne, Professor of Medicine,.....	95
Etiology of Eclampsia, Dr. L. V. Sams,.....	106
Diagnosis and Treatment of Ectopic Gestation, Dr. J. C. McGee,.....	110
Dr. J. C. Shaw,.....	114
EDITORIAL,.....	121
EDITORIAL CLIPPINGS,	125
SOCIETY NOTES,.....	127
NEWS NOTES,.....	129
CASE REPORTS,.....	131
REVIEWS,.....	132
MISCELLANEOUS,.....	133
CLINICAL NOTES,.....	137

Antitoxin that justifies your confidence

OUR Concentrated Antidiphtheric Serum (Globulin) is evolved in the blood of healthy, vigorous horses—horses that are carefully selected, and that have been pronounced sound by expert veterinarians. It is perfected in laboratories that afford unequaled facilities for serum production—laboratories in which it is possible to observe, at every step of the process, the vital principles of asepsis. It is exhaustively tested—bacteriologically for purity, physiologically for activity.



The antitoxic potency of our Concentrated Antidiphtheric Serum (Globulin) is expressed in units (Ehrlich standard, as approved by the United States Public Health and Marine Hospital Service), and each package is numbered to correspond to the number of antitoxic units it contains.

Bio. 15— 500 antitoxic units.
Bio. 16—1000 antitoxic units.
Bio. 17—2000 antitoxic units.
Bio. 18—3000 antitoxic units.

Bio. 19— 4000 antitoxic units.
Bio. 20— 5000 antitoxic units.
Bio. 21— 7500 antitoxic units.
Bio. 22—10,000 antitoxic units.

Specify Parke, Davis & Co.'s Concentrated Antidiphtheric Serum (Globulin) on your orders. Have assurance that the antitoxin which you administer is of guaranteed purity, potency and uniformity.

PARKE, DAVIS & COMPANY

Laboratories: Detroit, Mich., U.S.A.; Walkerville, Ont.; Hounslow, Eng.

Branches: New York, Chicago, St. Louis, Boston, Baltimore, New Orleans, Kansas City, Minneapolis, Seattle; London, Eng.; Montreal, Que.; Sydney, N.S.W.; St. Petersburg, Russia; Bombay, India; Tokio, Japan; Buenos Aires, Argentina.

Neo-Salvarsan

AND THE

Apparatus for administering same, both by intravenous and intramuscular injection.

We also have a large and up-to-date stock of all Surgical Instruments, Leather Goods, Rubber Goods and Furniture; including Physician's Office and Hospital Equipment. Send for Catalogue.

**Especially Elastic Goods, Supporters,
Trusses and Hosiery.**

Physician's Supply Company,

1005-07 WALNUT STREET, KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Conservation of the Ethmoid, Joseph E. Sawtell, M. D.....	139
Inertia Uteri, E. W. Reed, M. D.,.....	144
Hemorrhages—Antepartum and Postpartum, E. A. Reeves, M. D.....	146
Sinusitis, Clarence Zugg, B. S., M. D.,.....	151
Foreign Bodies in the Air Passages and the Oesophagus, R. H. T. Mann, M. D.,.....	155
EDITORIAL.....	159
SOCIETY NOTES,.....	174
NEWS NOTES,.....	175
OBITUARY,.....	176
COMMUNICATIONS,.....	177
ANNOUNCEMENTS,.....	178
MISCELLANEOUS,.....	178
CLINICAL NOTES,.....	181

Hypodermatic-tablet efficiency

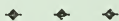
depends upon two things.

HYPODERMATIC TABLETS cannot be judged by outward signs. A dozen tablets from a dozen sources may look exactly alike. But mere appearance counts for little. **CONTENT** and **SOLUBILITY**—these are the things of paramount importance.



The practitioner who uses Parke, Davis & Co.'s hypodermatic tablets may do so with full assurance of their reliability.

Our hypodermatic tablets are composed of rigidly tested materials. They are of uniform strength, of guaranteed potency. In every tablet the active component is present in the precise amount stated on the label.



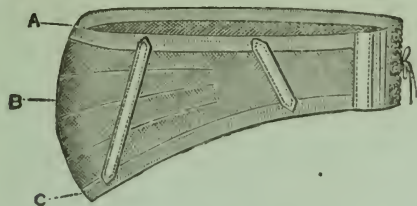
As to solubility, remember that merely to fly into pieces when thrown into water is not the requirement. Many tablets do that, fine undissolved particles settling to the bottom. In such a case the supernatant liquid which you draw into your syringe is not the solution you believe it to be, nor can it be expected to yield the desired results.

Our hypodermatic tablets dissolve quickly and completely: they do not merely disintegrate. In a very few seconds you have, ready to inject, a perfect solution of which every minim is a minim of activity. There is no delay, no uncertainty.



Use our hypodermatic tablets. Get results—get them promptly.

SUPPLIED IN TUBES OF 25.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
President's Address, Dr. Geo. M. Gray.....	183
Tabes Dorsalis and Allied States; Three Clinical Cases, Dr. A. L. Skoog	198
EDITORIAL.....	206
SOCIETY NOTES.....	218
NEWS NOTES.....	220
OBITUARY.....	221
RESOLUTIONS.....	221
REVIEWS.....	222

Accuracy in therapeutics

THE practicing physician wants a definite result from a definite dosage.

He does not always get it. Why?

Variability in the remedial agents of the market is largely responsible. Preparations of questionable quality and potency are far too common. Administration of such products is most uncertain medication.

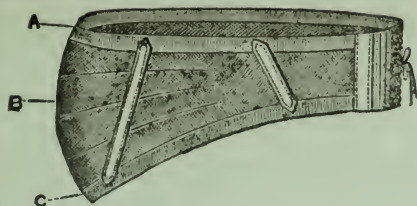
♦ ♦ ♦

There is one method by which the therapeutic worth of medicinal preparations may be definitely determined before administration. That method is by *assay*, chemical or physiological. That method is *our* method.

To the utmost degree possible in the present development of chemical and pharmacological knowledge, we standardize our entire output of pharmaceutical and biological products—our fluid, solid and powdered extracts; tinctures, elixirs, pills, tablets, serums, vaccines—chemically so far as practicable, physiologically when the former method is inexpedient. **WE WERE PIONEERS IN STANDARDIZATION**, both chemical and physiological.

♦ ♦ ♦

Specify "Parke, Davis & Co." when ordering or prescribing. Have positive assurance that the agents which you administer are therapeutically efficient and of definite medicinal strength.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Some Cases of Brain Surgery in a Country Doctor's Practice, E. E. Liggett, M. D.....	225
Social Activities in the Third District, H. B. Caffey M. D.....	233
The Surgical Situation in Kansas from the General Practitioner's Standpoint, T. A. Jones, M. D.....	237
EDITORIAL.....	243
Proceedings of the Kansas Medical Society.....	244
SOCIETY NOTES.....	257
NEWS NOTES.....	258
OBITUARY.....	259
REVIEWS.....	259
MISCELLANEOUS.....	262
CLINICAL NOTES.....	264

The Fourth of July

and Tetanus.

Notwithstanding the antiseptic precautions ordinarily observed, tetanus from Fourth-of-July injuries is of common occurrence, seemingly trivial wounds not infrequently being followed by tetanic symptoms and fatal results.

Prompt subcutaneous injection of

Antitetanic Serum, P. D. & Co.,

is suggested in all cases in which there is reason to fear that infection with tetanus bacilli may have taken place. In the treatment of suspicious injuries such injection is not only justifiable, but actually demanded by present methods of prophylactic therapeutics.



Antitetanic Serum, P. D. & Co., is prepared in our biological laboratories under strictly aseptic conditions. It is exactly standardized. Its purity and potency are assured by an elaborate series of bacteriologic and physiologic tests.

Bio. 140. 1500 units in plain bulb, boxes of 3.
Bio. 141.* 1500 units in syringe container.
Bio. 142. 3000 units in syringe container.
Bio. 143. 5000 units in syringe container.

**Supplied on unspecified orders.*

We also supply **Antitetanic Dusting Powder** for the treatment of wounds infected, or suspected of being infected, with tetanus germs. It is commonly used in conjunction with **Antitetanic Serum, P. D. & Co.** (Vials of 1 gram.)

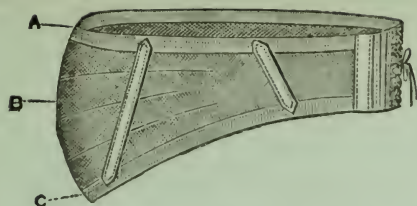


Druggists should be urged to have supplies of our **Antitetanic Serum** and **Antitetanic Dusting Powder** on hand for emergencies.

SPECIFY "P. D. & CO." ON YOUR ORDERS.

Home Offices and Laboratories,
Detroit, Michigan.

Parke, Davis & Co.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Modern Methods in the Diagnosis of Syphilis, Dr. H. M. Conner.....	265
Obstruction of the Upper Air Passages, Dr. J. R. Scott.....	273
The Present Approved Methods of Treatment of Obstructions to the Lacrimo-Nasal Duct, Dr. E. N. Robertson.....	279
The Importance of Inspection and Standards for Medicinal Substances, Prof. L. E. Sayre.....	285
EDITORIAL.....	292
EDITORIAL CLIPPINGS.....	297
SOCIETY NOTES.....	298
NEWS NOTES.....	299
OBITUARY.....	299
REVIEWS.....	300
MISCELLANEOUS.....	301
CLINICAL NOTES.....	304

Hay Fever and the **Adrenalin Treatment**

THE suprarenal substance, in the form of its isolated active principle, Adrenalin, is the chief reliance of a host of physicians.

And well it justifies their confidence.

Adrenalin effectually controls the nasal discharge. It cuts short the violent sneezing paroxysms. It aborts the annoying lacrimation. Nasal obstruction disappears under its use. Cough and headache subside. Natural breathing is resumed. Distress gives way to comfort.

These are the forms commonly used:

Solution Adrenalin Chloride

Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chloretone), 1000 parts.

Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx.

Ounce glass-stoppered bottles.

Adrenalin Inhalant

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts.

Dilute with three to four times its volume of olive oil and administer in the manner described above.

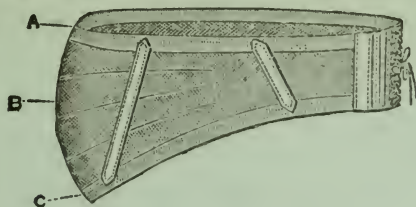
Ounce glass-stoppered bottles.



THE GLASEPTIC NEBULIZER

is an ideal instrument for spraying the solutions above mentioned. It produces a fine spray and is suited to oils of all densities, as well as aqueous, spirituous and ethereal liquids.

Price, complete (with throat-piece), \$1.25.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.



Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
The Gall-Bladder, E. E. Hubbard, M. D., C. M.....	305
Pseudoleukemia. Dr. Ralph H. Hertzler,.....	313
Office Treatment of Pelvic Diseases, J. T. Scott, M. D.....	318
The Relation of the Puerperium to the Present and Future Health of Woman, Dr. W. C. Bundrant.....	324
EDITORIAL.....	328
EDITORIAL CLIPPINGS.....	329
SOCIETY NOTES.....	330
NEWS NOTES.....	331
OBITUARY.....	332
COMMUNICATIONS.....	332
REVIEWS.....	333
MISCELLANEOUS.....	337
CLINICAL NOTES.....	341

Hay Fever and the --- Adrenalin Treatment ---

THE suprarenal substance, in the form of its isolated active principle, Adrenalin, is the chief reliance of a host of physicians.

And well it justifies their confidence.

Adrenalin effectually controls the nasal discharge. It cuts short the violent sneezing paroxysms. It aborts the annoying lacrimation. Nasal obstruction disappears under its use. Cough and headache subside. Natural breathing is resumed. Distress gives way to comfort.

These are the forms commonly used:

Solution Adrenalin Chloride

Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chloretone), 1000 parts.

Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx.

Ounce glass-stoppered bottles.

Adrenalin Inhalant

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts.

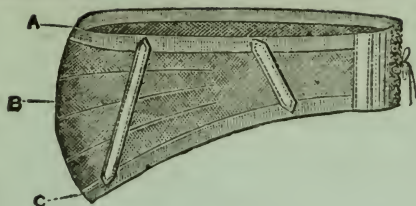
Dilute with three to four times its volume of olive oil and administer in the manner described above.

Ounce glass-stoppered bottles.

♦ ♦ ♦

THE GLASEPTIC NEBULIZER

is an ideal instrument for spraying the solutions above mentioned. It produces a fine spray and is suited to oils of all densities, as well as aqueous, spirituous and ethereal liquids.
Price, complete (with throat-piece), \$1.25.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

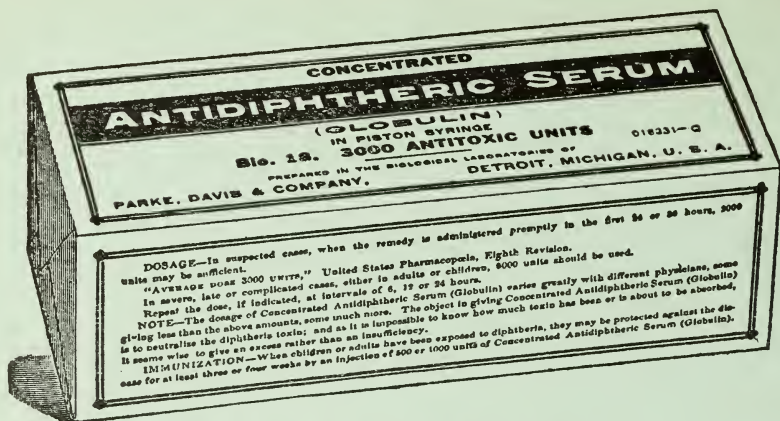
Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
The Pathology of Chronic Arthritis, Lindsay S. Milne, M. D.	345
Some Recent Medical Legislation—The Remedy—What? Dr. F. A. Carmichael,	355
Theoretical vs. Practical Politics in Medical Legislation, Dr. J. J. Sippy .	362
The Medical Man in the Legislature, J. S. Cummings, M. D.	370
EDITORIAL	373
EDITORIAL CLIPPINGS	375
SOCIETY NOTES	378
NEWS NOTES	378
OBITUARY	380
REVIEWS	380
MISCELLANEOUS	382
CLINICAL NOTES	382



NO GUESSWORK

WHEN YOU USE OUR

Antidiphtheric Serum

(GLOBULIN)

Parke, Davis & Co.'s Concentrated Antidiphtheric Serum (Globulin) is manufactured with scientific precision, under the direct supervision of expert bacteriologists. It goes to the physician with a positive guaranty of purity and activity. It is supplied in the most satisfactory syringe container ever offered to the medical profession.

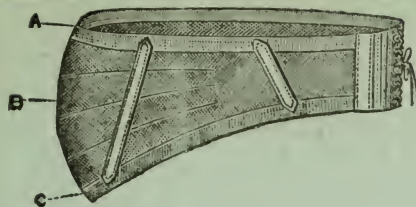
Bio. 15— 500 antitoxic units.
 Bio. 16—1000 antitoxic units.
 Bio. 17—2000 antitoxic units.
 Bio. 18—3000 antitoxic units.

Bio. 19— 4000 antitoxic units.
 Bio. 20— 5000 antitoxic units.
 Bio. 21— 7500 antitoxic units.
 Bio. 22—10,000 antitoxic units.

Specify Parke, Davis & Co.'s Concentrated Antidiphtheric Serum (Globulin) on your order.

PARKE, DAVIS & COMPANY

Home Offices and Laboratories, Detroit, Michigan.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.



Physician's Supply Company,

1005-07 WALNUT STREET,

KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
The "Feeble-Minded" as revealed by the Binet-Simon Measuring Scale for Intelligence, Dr. E. E. Liggett.....	385
Veratrum Viride in Puerperal Eclampsia, Dr. F. M. Wiley.....	393
Auto-Intoxication, Dr. M. S. Thacher.....	397
Toast—"The Doctor," Dr. S. L. Brooking.....	401
"What Are We Going To Do About It?" Dr. Chas. E. Seiver.....	409
EDITORIAL.....	413
EDITORIAL CLIPPINGS.....	415
SOCIETY NOTES.....	416
NEWS NOTES.....	418
OBITUARY.....	419
REVIEWS.....	420
MISCELLANEOUS.....	421
CLINICAL NOTES.....	422

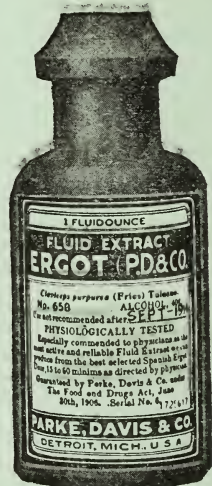
Ergot: Does it ever fail you?

If your experience is the experience of most physicians, it will pay you to read every word of this announcement.

DETERMINED to supply the medical profession with the best possible Fluid Extract of Ergot, we have adopted these simple and sensible precautions:

1. Only genuine Spanish Ergot of prime quality is employed, and the drug is physiologically tested.
2. The menstruum and the manipulation during extraction assure the most active and permanent product possible.
3. The fluid extract is carefully tested by physiologic methods to insure activity and uniformity.
4. It is marketed in amber bottles, each enclosed in a carton which protects it from light.
5. It is supplied in *one-ounce vials only*.
6. This small bottle is designed for dispensing on the physician's prescription. It guarantees an original package, prepared and kept under the best possible conditions. It obviates the likelihood of getting Ergot from a partly emptied container with consequent deterioration through oxidation or loss of alcohol.
7. The label on each carton and vial bears a date, after the expiration of which we do not advise the use of the fluid extract.

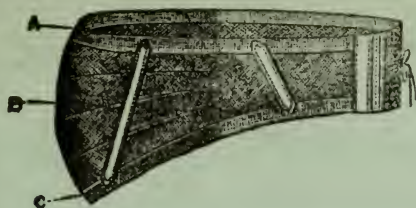
Fluid Extract Ergot (P. D. & Co.), in original packages. Specify it!



Our new
ounce package.

Home Offices and Laboratories,
Detroit, Michigan.

Parke, Davis & Co.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

Physician's Supply Company,

1005-07 WALNUT STREET,

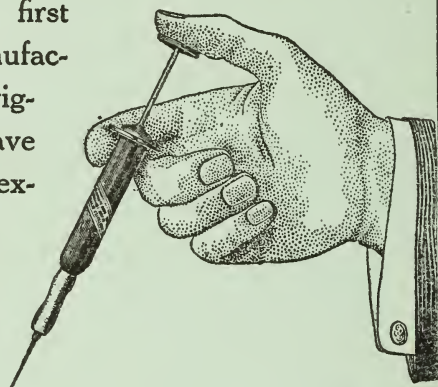
KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
Acute Infections of the Peritoneum, Dr. N. C. Morrow.....	425
Ulcer of the Stomach, Dr. Robert B. Gibb.....	430
The So-Called Social Evil, Dr. P. S. Mitchell.....	434
Trachoma, Dr. C. A. Landes.....	441
The Fact Versus the Mental Impression, Dr. W. R. Heylman.....	446
EDITORIAL.....	449
EDITORIAL CLIPPINGS.....	453
SOCIETY NOTES.....	455
NEWS NOTES.....	459
CASE REPORTS.....	460
REVIEWS.....	461
MISCELLANEOUS.....	462
CLINICAL NOTES.....	468

Our diphtheria antitoxin is **PROVED** antitoxin

THE proof begins with the first step in the process of manufacture—the selection of healthy, vigorous horses: animals that have been pronounced sound by expert veterinarians. It ends only when the finished product is wrapped and labeled for the market.



CONCENTRATED Antidiphtheric Serum (GLOBULIN)

is tested and retested—bacteriologically for purity, physiologically for activity. It is sterile. It is of accurately demonstrated antitoxic strength. The syringe container in which it is marketed is a model of convenience and security.

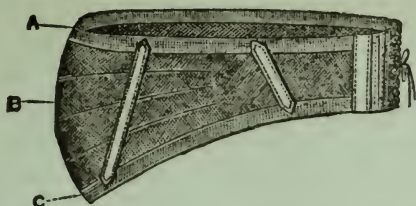
Bio. 15— 500 antitoxic units.
Bio. 16—1000 antitoxic units.
Bio. 17—2000 antitoxic units.
Bio. 18—3000 antitoxic units.

Bio. 19— 4000 antitoxic units.
Bio. 20— 5000 antitoxic units.
Bio. 21— 7500 antitoxic units.
Bio. 22—10,000 antitoxic units.

ALWAYS SPECIFY "P. D. & CO." WHEN YOU ORDER.

Home Offices and Laboratories,
Detroit, Michigan.

Parke, Davis & Co.



Abdominal Supporters, Elastic and Hosiery.

We are also in a position to supply everything in up-to-date Surgical Instruments, Leather Goods, Rubber Goods and Furniture, including Physicians' Office and Hospital Equipment.

Physician's Supply Company,

1005-07 WALNUT STREET,

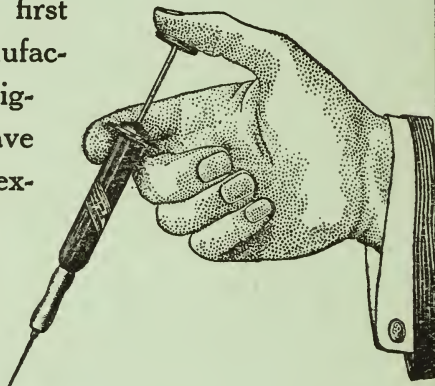
KANSAS CITY, MISSOURI.

CONTENTS.

	PAGE
The Benzol Treatment of Leukaemia. Lindsay S. Milne, M. D.....	467
Irresponsible Medicine, Dr. Noah Hayes.....	476
Effects of Explosion of Dynamite Caps on The Tympanum and External Ear, Dr. R. S. Magee.....	481
Relation of the Physician and the Editor, J. L. Napier.....	483
EDITORIAL.....	487
SOCIETY NOTES.....	491
NEWS NOTES.....	491
OBITUARY.....	493
RESOLUTIONS.....	494
REVIEWS.....	495
MISCELLANEOUS	500
CLINICAL NOTES.....	505

Our diphtheria antitoxin is **PROVED** antitoxin

THE proof begins with the first step in the process of manufacture—the selection of healthy, vigorous horses: animals that have been pronounced sound by expert veterinarians. It ends only when the finished product is wrapped and labeled for the market.



CONCENTRATED Antidiphtheric Serum (GLOBULIN)

is tested and retested—bacteriologically for purity, physiologically for activity. It is sterile. It is of accurately demonstrated antitoxic strength. The syringe container in which it is marketed is a model of convenience and security.

Bio. 15— 500 antitoxic units.
Bio. 16—1000 antitoxic units.
Bio. 17—2000 antitoxic units.
Bio. 18—3000 antitoxic units.

Bio. 19— 4000 antitoxic units.
Bio. 20— 5000 antitoxic units.
Bio. 21— 7500 antitoxic units.
Bio. 22—10,000 antitoxic units.

ALWAYS SPECIFY "P. D. & CO." WHEN YOU ORDER.

Home Offices and Laboratories,
Detroit, Michigan.

Parke, Davis & Co.



4/A 60+

